

# Board for Licensing Health Care Facilities

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**CURRENT POLICIES)**

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BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 1

SUBJECT: Hospitals in Penal Institutions

DATE: November 19, 1980

That: The interpretation of the Board is that hospitals in penal institutions do not come under jurisdiction of this Board.

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 5

SUBJECT: Change of Ownership Notification

DATE: March 17, 1982

That: The Board communicate to the health care facilities about changes in ownership requirements and bring before this Board anyone who does not properly notify the department of change in ownership.

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 6

SUBJECT: Night Light Switch

DATE: May 19, 1982

That: Matters regarding a continuously burning night light switch not be cited as a deficiency.

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 7

**SUBJECT:** Patient Room Door Closures

**DATE:** August 18, 1982

**That:** The Board recommend to the Task Force (on Fire Safety) that the requirement of self-closing devices for patient room doors be deleted from the regulations.



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DEPARTMENT OF HEALTH  
DIVISION OF HEALTH LICENSURE & REGULATION  
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PM 8 Amended

Board for Licensing Health Care Facilities

Policy Memorandum

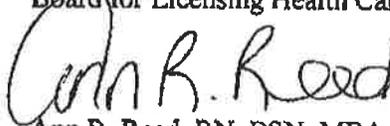
**SUBJECT:** Emergency Admissions

**DATE:** February 7, 2013

**POLICY:** The Board requires prior approval by Office of Health Care Facilities' staff for an increase in patients above the licensed bed capacity for Residential Homes for the Aged (RHA) and Assisted Care Living Facilities (ACLF).

**EFFECTIVE:** February 7, 2013

**APPROVED:**   
Robert Gordon, Chairman Pro Tem  
Board for Licensing Health Care Facilities

  
Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 9

SUBJECT: Waiver Requests To Be From Chief Executive Officer

DATE: August 19, 1982

That: The waiver be granted subject to two conditions:  
The first condition (to) be the receipt of a formal  
request from the Chief Executive Officer of the  
hospital,  
and  
The second request (condition) being that the Board be  
provided with a written report in one year of this pro-  
ject.

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 10

SUBJECT: Reports on Sibling Visitation Waivers

DATE: August 19, 1982:

That: The Board direct Staff to not require the appearance of a representative when the experience has been positive with sibling visitations.

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 11

**SUBJECT:** Pre-Board Meeting(s) With Facilities

**DATE:** August 19, 1982

**That:** The Staff, especially the Engineering Staff, have at least one meeting with the proper authorities of each facility in question, and try to resolve the problems before they come to the Board.

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 12

SUBJECT: Home Health Agency Within Nursing Home

DATE: November 17, 1982

That: Staff be granted the authority to grant waiver requests which relate to locating a Home Health Agency within a long term care facility.

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 17

SUBJECT: Unannounced Inspections

DATE: April 6, 1983

That: All licensure inspections be made unannounced except those involving changes of ownerships or initial inspections.

## BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 21

SUBJECT: CON Requirements for Home Health Agencies

DATE: January 7, 1985

CON is required or approval from the Health Facilities Commission:

1. \*Change of ownership;
2. Sub-Units;
3. Addition of counties or service area;
4. New agencies;
5. To close or 60 days prior notice given.

CON is not required for:

1. Change of address only when in licensed service area;
2. Branch offices within licensed service area;
3. Addition of services.

\*On a change of ownership a form called Notification of Intent to Acquire an Existing Health Care Institution is required by the Health Facilities Commission.

## BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 23

SUBJECT: Emergency Admission Policy

DATE: October 27, 1986

That: To comply with the Board's determination that prior approval be obtained for emergency admissions and that facilities that continually request such be brought before them. The following procedures will be followed:

1. Facility administrator to submit in writing a request with, medical and social information, statement of lack of beds in area and how the patient will be housed.
2. Review facility file to verify that the facility is not currently overbedded and how often facility is requesting emergency admissions.
3. Obtain approval from Medical Director.
4. Notify facility by telephone of decision.
5. Send approval letter.
6. Place information in log.
7. Facility to notify the Department in writing, when it returns to licensed bed capacity.

BOARD FOR LICENSING HEALTH CARE FACILITIES  
POLICY MEMORANDUM NUMBER 24

SUBJECT: EMS Personnel - In Hospital Emergency Rooms

DATE: November 17, 1987

The Board approved the following policy on September 9, 1987:

Employees of the ambulance service cannot be used within the hospital as licensed nursing staff. Ambulance service personnel such as paramedics shall not function in the hospital as a licensed nurse (doing nursing duties) or in place of a licensed nurse. Certified EMS personnel may assist in the emergency room under the direct supervision of a Registered Nurse.

If a hospital provides clinical facilities for the education and training of (Emergency Medical Technicians) or Paramedics, there must be a written agreement that defines the role and responsibility of the hospital, nursing service and the education program.

Emergency Department personnel shall be trained for their responsibilities through appropriate training and education programs. At a minimum, emergency room nursing staff must have ACLS training.

AN/G5127321

Board for Licensing Health  
Care Facilities

Policy Memorandum Number 26

**Subject:** One (1) Residential Home for Aged Administrator May Serve More Than One (1) Licensed Facility

**Date:** March 27, 1991

**That:** One (1) administrator may serve more than one (1) licensed facility if all licensed facilities are on the same campus, or if all licensed facilities do not exceed fifty (50) beds, nor are more than fifty (50) miles apart from the administrator's location based on the "Tennessee Official Highway Map". Every facility however, must have a "responsible attendant".

In addition, the certified residential home for aged administrator must visit each of the areas where a "responsible attendant" is located at least one (1) day or eight (8) hours per week.

SP/GS081178

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 28

**SUBJECT:** Course Curriculums for Certified RMA Administrators  
**DATE:** June 13, 1990

**THAT:** The Board grant Staff the authority to review and approve course curriculums to be offered to certified administrators of Residential Homes for the Aged.

If Staff has a problem with the curriculum of any courses, Staff is directed to present them to the Board at its next available meeting.



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BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 29

SUBJECT: Consent Calendar  
DATE: December 30, 1991 *[Signature]*  
THAT: The Board Directs Staff to Develop a Consent Calendar.

The Board has requested that staff place certain types of waiver requests on the consent calendar. They are waiver requests which are recommended by staff for Board approval. The requests are well justified, do not have a detrimental effect on the health, safety, and welfare of the public and have routinely been approved by the Board.

A representative from the facility does not have to be present at the Board meeting.

Staff, as always, shall notify the facility of the Board's decision.

HB/G5071364



Board for Licensing Health

Care Facilities

Policy Memorandum Number 31

**Subject:** Residential Home for Aged - Non Refundable Application Fee clause  
be deleted.

**Date:** March 27, 1991

**Policy:** Gives staff the authority to refund, if conditions warrant, the application fee for Residential Home for Aged, until such time as the regulations are amended to delete the non-refundability clause.

  
**Approved:** Helmut (John) Bonkowski, Director  
Board for Licensing  
Health Care Facilities

BF/G5141113

**cc:** LRB  
BK  
RB  
AG  
OGC



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[www.tennessee.gov/health](http://www.tennessee.gov/health)**

PM 32 AMENDED

Board for Licensing Health Care Facilities

Policy Memorandum

**SUBJECT:** Authority for Staff to Grant Waivers for Facilities to Provide Outpatient Therapy.

**DATE:** August 2, 2006

**POLICY:** Gives staff authority to grant waivers, subject to Board ratification, to nursing homes and residential homes for the aged to provide outpatient physical therapy, occupational therapy, speech therapy to non-residents if proper guidelines, criteria, staffing and protocol are submitted.

*Guidelines, criteria, staffing and protocol include, but are not limited to:*

- Facility maintains adequate staff to meet the needs of residents and outpatients.
- Outpatient therapy services are accessible via separate entrance or entrance without going through resident care areas.
- If therapy services are provided to a resident of the facility, services are provided only in rehab designated areas and not in resident's living quarters.

**APPLICABILITY:** This policy will apply to Nursing Homes and Residential Homes for the Aged.

**PROCEDURE:** A facility shall make a request in writing to the Director, Board for Licensing health Care Facilities. The request shall be placed on the Consent Calendar for the next scheduled Board Meeting.

**APPROVED:** Katy Gammon  
Director  
Health Care Facilities



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Policy Memorandum Number 36

Date: July 24, 1992

Subject: Labor Delivery Recovery Post-Partum Waiver requests being placed on Consent Calendar

Policy: That the staff place waiver requests to build or construct Labor Delivery Recovery Post-Partum Rooms which have appropriate staffing, and are within close proximity to Surgery, on the Consent Calendar.

Approved:  Helmut (John) Bonkowski, Director  
Board for Licensing Health Care Facilities

HJB/BF/G6132195

cc: LAB  
EK  
RB  
AG  
OGC  
JOC



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PM 39

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM  
AMENDED

**SUBJECT:** Nursing Home Administrators permitted to serve as administrators of Residential Homes for Aged and Assisted Care Living Facilities.

**DATE:** May 12, 1999

**POLICY:** When a nursing home is adjacent or connected to a Home for Aged or Assisted Care Living Facility, a request for the administrator to serve both facilities may be placed on the Consent Calendar to be considered at the next board meeting.

**APPROVED:** <sup>K</sup>Katy Gammon, Director  
Board for Licensing  
Health Care Facilities



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PM 44

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM NUMBER 44

**SUBJECT:** Transportation of Contaminated Waste

**DATE:** March 24, 1993

**POLICY:** That in lieu of Section 1200-8-2-.02(8)(e) of the hospital Regulations pertaining to the required incineration or proper disposal of infectious wastes, hospitals shall follow the applicable OSHA Regulations found at 29 C.F.R. 1910.1030, et seq. when transporting explanted breast implants or similar infectious wastes to another party until the regulations can be amended.

cc: JMF  
HJB  
RAB  
MH  
SJ  
OGC  
JOC



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FM 45

BOARD FOR LICENSING HEALTH CARE FACILITIES  
POLICY MEMORANDUM 45

**SUBJECT:** Hospital Definitions for Licensure Purposes

**DATE:** December 14, 1994

**POLICY:** The definition of a hospital is: "A hospital means any institution, place, building or agency representing and held out to the general public as ready willing and able to furnish care, accommodations, facilities and equipment for the use and in connection with services of a physician or dentist for one or more non-related persons who may be suffering from deformities, injuries or disease or any other condition for which nursing, medical or surgical services would be appropriate for care, diagnosis or treatment."

The chronic disease classification is adopted for licensing of long term acute care hospitals until the regulations can be amended.

cc: JMF  
HJB  
RAB  
MH  
SJ  
OGC  
JOC



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CM 46

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM 46

SUBJECT: Hospital Licenses

DATE: December 14, 1994

POLICY: The Board's policy is that when a second hospital license is issued within a previously licensed hospital institution that it is considered a separate license but not a separate facility and falls under existing previously approved fire codes, unless there is major renovation. If there is major renovation, the new hospital has to be brought up to current fire safety standards, with major renovation being defined as renovation of fifty percent (50%) or more of the footage of the newly licensed facility.

cc: JMF  
HJB  
RAB  
MH  
SJ  
OGC  
JOC



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DIVISION OF HEALTH CARE FACILITIES  
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NASHVILLE, TENNESSEE 37247-0530

PM 47

BOARD FOR LICENSING HEALTH CARE FACILITIES  
POLICY MEMORANDUM 47

**SUBJECT:** Physician's Signature Requirement on Verbal Orders

**DATE:** March 15, 1995

**POLICY:** To extend the period of time for a physician to sign a verbal or telephone order from ten (10) days to thirty (30) days for Home Care Organizations.

cc: JMF  
HJB  
RAB  
MH  
SJ  
OGC  
JOC



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PM 48

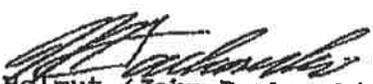
BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM 48

SUBJECT: Waiver Requests

DATE: February 14, 1996

POLICY: All waiver requests must be received (stamped in) in this office no later than two (2) weeks prior to the Board meeting.

  
APPROVED: Helmut (John) Bonkowski, Director  
Board For Licensing  
Health Care Facilities

cc: JMF  
HJB  
RAB  
MH  
SJ  
OGC  
JOC



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
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PM 49

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM

**SUBJECT:** Waiver Requests for Removal of Outdated Fire Protection Equipment

**DATE:** August 14, 1996

**POLICY:** Fire protection equipment such as deteriorating hose stored at facilities that local fire marshals have deemed no longer functional can be removed on the recommendation of the fire marshal.

**APPROVED:** Helmut (John) Bonkowski, Director  
Board for Licensing  
Health Care Facilities

cc: JMF  
RB  
MH  
SJ  
OGC  
LH  
CM



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PM 51 (AMENDED)

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM

**SUBJECT:** Nursing Homes and Hospitals sharing existing services / *all facility types*  
**DATE:** August 14, 1996  
**POLICY:** The Board's policy is that any licensed facility located within another licensed facility or located on the same campus be allowed to share the following services:

1. Dietary
2. Housekeeping
3. Laundry
4. Laboratory
5. Pharmacy
6. Maintenance
7. Security
8. Radiology
9. Physical Therapy
10. Speech Therapy
11. Respiratory Therapy
12. Occupational Therapy

The Board for Licensing Health Care Facilities request that staff place these waiver requests on the Consent Calendar when it does not pose a threat to public safety.

**APPROVED:** Melante Hill, Director *MH*  
Board for Licensing  
Health Care Facilities



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PM 52

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM

**SUBJECT:** Door Width Requirements for Residential Homes for the Aged and Institutional Homes for the Aged

**DATE:** August 14, 1996

**POLICY:** The Board's policy is to allow RHAs and IHAs to utilize thirty six inch (36") wide patient room doors.

The Board for Licensing Health Care Facilities request that staff place these waiver requests on the consent calendar when it does not pose a threat to public safety.

**APPROVED:** Helmut (John) Bonkowski, Director  
Board for Licensing  
Health Care Facilities

cc: JMF  
RB  
MH  
SJ  
OGC  
LH  
CM



**TENNESSEE DEPARTMENT OF HEALTH  
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PM 58 AMENDED

**BOARD FOR LICENSING HEALTH CARE FACILITIES**

**POLICY MEMORANDUM**

**SUBJECT:** Substantial Renovation

**DATE:** Proposed Amendment November 12, 1997; Amended February 7, 2007

**POLICY:** The following are criteria for which projects would require review by the engineering department under the substantial renovation requirement:

- (1) Projects that renovate more than ten percent (10%) of any smoke compartment.
- (2) Areas renovated less than ten percent (10%) must meet the following to be exempt from submitting plans to the engineering department:
  - (a) All work must be executed in accordance with currently adopted codes.
  - (b) Only one renovation shall be initiated during any one year period.
  - (c) No licensure deficiencies are cited as of last survey.
  - (d) Shall not involve combustible or medical gas or be classified as hazardous.
  - (e) Does not change or alter the existing life safety classification.
  - (f) Does not change or alter construction type or life safety of the facility.
  - (g) Does not alter any of the following systems:
    1. Fire Alarm System
    2. Fire Suppression System
    3. Mechanical System
    4. Electrical System
- (3) Projects that are strictly cosmetic in nature need not be submitted provided that improvements are limited to surface treatments and do not change any existing life safety conditions and such improvements shall meet all applicable codes.

When any project meets that above criteria for exemption from plans submittal, the licensee shall submit a statement of the project scope and justification. Upon review of the data, the Director of Engineering may require additional information from an architect or engineer registered in the State of Tennessee.

**EFFECTIVE:** April 16, 2007

**APPROVED:** Ann Thompson, RN, Director  
Board for Licensing Health Care Facilities  
Board Approved February 7, 2007



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
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Effective Date: June 24, 1998

PM 59

DRAFT BOARD POLICY MEMORANDUM  
HOME CARE ORGANIZATIONS PROVIDING HOME HEALTH SERVICES

**PURPOSE:** To clarify the intent of the Board's regulations governing Home Care Organizations providing Home Health Services.

The Board has voted to clarify the intent of the regulations pertaining to licensed Home Care Organizations providing Home Health Services by adopting the following policy as guidance in surveying such agencies:

**POLICY:**

The Board for Licensing Health Care Facilities "Standards for Home Care Organizations Providing Home Health Services" are not applicable if a patient served by the home care organization only receives homemaker services. It is the responsibility of the home care organization to identify such patients to the surveyor.

**Example:** A licensed home health agency is not required to develop a plan of care for anyone that is only receiving homemaker services from the agency.

**EFFECTIVE:** Until amended or revoked by the Board.



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PM 62

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM

**SUBJECT:** Standards for Medical Equipment Providers

**PURPOSE:** To establish uniform standards for medical equipment providers

**DATE:** February 10, 1999

**POLICY:** Medical equipment delivery technicians, who install respiratory equipment shall be deemed competent with their employer prior to independently delivering and setting up the respiratory equipment. The home medical equipment supplier must maintain documentation to demonstrate that competency requirements are met.

Standard competencies will include at a minimum the following: Role responsibilities; Cylinders; Pressure regulators/Flow controllers; Home liquid oxygen systems; Oxygen concentrators; Oxygen Administration; Oxygen Analyzers; Humidifiers; and Aerosol generators.

APPROVED:  Katy Gammon, Director  
Board for Licensing  
Health Care Facilities



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PM 68

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM

- SUBJECT:** Consistent Board Definition of "Justified Emergency" for exceeding licensed bed capacity.
- DATE:** May 13, 1998
- POLICY:** In the event of a justified emergency, a hospital may exceed its licensed bed capacity. A "Justified emergency" includes, but is not limited to, the following events/emergencies:
1. An influx of mass casualties;
  2. Localized and/or regional catastrophes, i.e., storms, earthquakes, tornadoes; and,
  3. Epidemics or episodes of mass illness, i.e., influenza, salmonella, etc.
- PROCEDURE:** When a hospital determines the need to, and then does subsequently, exceed its licensed bed capacity the following procedures must be followed:
1. The hospital's administrator must make written notification to the Department within forty-eight (48) hours of exceeding its licensed bed capacity;
  2. The notification must include a detailed description of the emergency including:
    - a. Why the licensed bed capacity was exceeded, i.e., lack of hospital beds in vicinity, specialized resources only available at the facility, etc.;
    - b. The estimated length of time the licensed bed capacity is expected to be exceeded; and,
    - c. The number of admissions in excess of the facility's licensed bed capacity.
  3. As soon as the hospital returns to its licensed bed capacity, the administrator must notify the Department in writing of the effective date of its return to compliance;
  4. Staff will review all exceeding bed capacity notifications with the Chairman of the Board and if, upon review, Department staff concurs that a justified emergency existed, staff will notify the facility in writing and then report the occurrence to the Board at the next regularly scheduled Board meeting as information only.

**PM 68 continued**

5. However, if Department staff does not concur that a justified emergency existed, the facility will be notified in writing that a representative is required to appear at the next regularly scheduled Board meeting to justify the need for exceeding its licensed bed capacity.

**EFFECTIVE:** Until such time as the Board determines the need to modify the policy and/or procedure.

**APPROVED:** Katy Gammon, Director  
Board for Licensing  
Health Care Facilities

Effective: May 12, 1999

**PURPOSE:** Allow the Department to use exceptions permitted by the codes.

**POLICY:** Allow the Department to apply the code related exception, whether more or less restrictive, when there are conflicts between the requirements in codes and regulations.

**APPLICABILITY:** This policy would apply to the following regulations

- |  |                     |
|--|---------------------|
| 1. Hospitals                           | 1200-8-2-.01(1)(a)  |
| 2. Homes for the Aged                  | 1200-8-110.07(3)    |
| 3. A & D Res. Rehabilitation Treatment | 1200-8-17-.09(1)(b) |
| 4. A & D Primary Prevention Treatment  | 1200-8-20-.08(1)    |
| 5. A & D Non Res. Methadone Treatment  | 1200-8-21-.08(1)    |
| 6. A & D Halfway House Treatment       | 1200-8-22-.09(1)(b) |
| 7. A & D Res. Detoxification Treatment | 1200-8-23-.09(1)(b) |
| 8. Birthing Centers                    | 1200-8-24-.07(4)    |
| 9. Assisted Care Living                | 1200-8-25-.07(3)    |

Language stated in the above regulations is: Where there are conflicts between Requirements in the above listed codes\* and regulations and provisions of this Chapter, the most restrictive shall apply.

Proposed Language for amendments to regulations are: Where there are conflicts between requirements in the above listed codes, regulations and provisions of this chapter, the Department shall have the option to apply the exceptions.

\*Codes includes: Standard Building Codes, Handicap Code as required by T.C.A. 68-120-204(a), the 1997 edition of the Standard Mechanical Code, Standard Plumbing Code, Standard Gas Code, the most current edition of the ASHRAE Handbook of Fundamentals, and the 1997 edition of the National Fire Protection Code (NFPA), NFPA 1 including Annex A which code incorporates the 1997 edition of the Life Safety Code and the 1997 National Electrical Code.



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PM 73

BOARD FOR LICENSING HEALTH CARE FACILITIES

POLICY MEMORANDUM

**SUBJECT:** Testing Skills for Nurse Aides

**DATE:** February 5, 2003

**POLICY:** Nurse aide candidates be required to pass five critical testing skills selected randomly for each registrant from a pool of skills evaluation tasks ranked according to degree of difficulty, with at least one task selected from each degree of difficulty.

**EFFECTIVE:** Until such time as the Nursing Home Regulations are amended to reflect this revision and become effective.

**APPROVED:** Cathy Green, Director  
Board for Licensing  
Health Care Facilities *approved 2/5/03 (CG)*



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PM 74

Board for Licensing Health Care Facilities  
Policy Memorandum

**SUBJECT:** Dantrolene in ASTC

**DATE:** February 4, 2004

**POLICY:** If a licensed Ambulatory Surgical Treatment Center does not administer general anesthesia, the ASTC shall not be required to maintain thirty-six (36) ampules of dantrolene for injection on site as required in ~~1200-8-10-06(g)~~: 1200-8-10-.06(2)(g).

**EFFECTIVE:** February 4, 2004

**APPROVED:** Cathy Green, RN, Director *CA*  
Board for Licensing Health Care Facilities  
Board Approved February 4, 2004



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PM 76

**Board for Licensing Health Care Facilities**

**Policy Memorandum**

**SUBJECT:** Licensure Approval by Board

**DATE:** March 12, 2008

**POLICY:** Health Care Facilities administrative staff shall initially approve licensure applications without disqualifying information. These applications shall be presented at the next scheduled Board meeting for ratification by the Board.

Applications presenting with disqualifying information shall be presented at the next scheduled Board meeting for review and subsequent approval or denial by the Board.

**EFFECTIVE:** March 12, 2008

**APPROVED:**

Larry Arnold, M.D., Chairman  
Board for Licensing Health Care Facilities

Ann R. Thompson, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities



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PM 77 Amended

Board for Licensing Health Care Facilities

Policy Memorandum

SUBJECT: Granted Waiver Request by the Board

DATE: January 14, 2016

POLICY: After a waiver request has been granted by the Board for Licensing Health Care Facilities, a Board letter is sent to the requesting facility informing them their waiver has been granted. The letter includes a request that the facility notify the Board for Licensing Health Care Facilities in writing when there is a change in the waiver status. A copy of this Board Policy will be attached with and referenced within the letter granting the waiver. Granted waivers are recorded in the Waiver Request notebook with the expiration date of the waiver.

Health Care Facilities' administrative staff performs an initial review of the Waiver Request notebook for those granted waiver requests with an expiration occurring within the upcoming quarter. A notification of status update letter is submitted to those facilities that have a granted waiver expiring within the upcoming quarter. All points of contact with the facility will be recorded in this Waiver Request notebook. A second review of the Waiver Request notebook will occur prior to the next scheduled Board meeting. After this review, OHCF administrative staff notifies those facilities continuing with waivers by telephone of the waivers upcoming expiration date. Any facility that has not satisfied the waiver requirement will then notify the Board for Licensing Health Care Facilities in writing requesting a waiver extension. The waiver extension request will be presented at the next scheduled Board meeting for consideration by the Board. If no waiver extension request is received in writing, Board administrative staff will presume the facility is in compliance and will be held to the standards of their licensure type.

Facilities that have been granted a waiver and who are now in compliance with the regulations shall notify the Board for Licensing Health Care Facilities in writing that they are now meeting all requirements.

APPROVED:



Jim Shulman, Chairman Pro Tem  
Board for Licensing Health Care Facilities



Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities



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PM 78

Board for Licensing Health Care Facilities

Policy Memorandum

**SUBJECT:** Department Authority on Change of Ownership (CHOWS) Applications

**DATE:** January 20, 2010

**POLICY:** Public Chapter 323 codified as Tennessee Code Annotated 68-11-1630 authorizes the Board for Licensing Health Care Facilities to grant the Department the authority to issue a new license to a successor/owner of a health care facility when there has been a change of ownership or control provided the Department determines that the successor/owner meets the following qualifications for licensure:

- (1) The successor/owner meets the qualifications for license;
- (2) The health care facility has no outstanding license or certification deficiencies; and
- (3) The successor/owner already owns or controls at least one (1) other health care facility in the state.

**EFFECTIVE:** January 20, 2010

**APPROVED:**

Larry Arnold, M.D., Chairman  
Board for Licensing Health Care Facilities

Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities



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PM 79

Board for Licensing Health Care Facilities

Policy Memorandum

**SUBJECT:** POST Form and 2013 Legislation

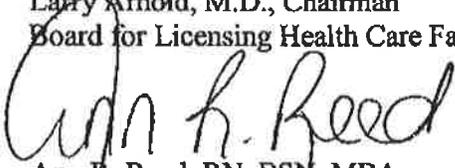
**DATE:** May 1, 2013

**POLICY:** Board approves that individuals referenced in SB257/HB1019 may sign their name and list their credentials on the line designated on the POST Form for the physician's signature until the form is amended for all licensed facility types.

**EFFECTIVE:** May 1, 2013

**APPROVED:**

  
Larry Arnold, M.D., Chairman  
Board for Licensing Health Care Facilities

  
Ann K. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities



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PM 80

Board for Licensing Health Care Facilities

Policy Memorandum

SUBJECT: Fire Sprinkler/NFPA 13

DATE: January 23, 2014

POLICY: Consistent with CMS requirements and practices of surrounding states who utilize the IBC Core Code without modification allow a single facility separated into individual buildings by common firewalls can be served by a single sprinkler system and riser subject to NFPA 13 codes.

EFFECTIVE: January 23, 2014

APPROVED:

Robert Gordon, Chairman Pro Tem  
Board for Licensing Health Care Facilities

Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities

\*\*\*Attached are supporting CMS requirements and practices of surrounding states.

## **I. CMS – Question and Response**

The following question was sent to CMS in Baltimore.

### **Question to CMS:**

"In a single existing or new nursing home under 52,000 sq. ft. under one roof/owner that has multiple fire areas separated by 4 hour fire walls would CMS allow the building to be supplied by a single sprinkler riser and allow the interior sprinkler piping to penetrate the 4 hour fire walls if the penetrations were properly protected and the sprinkler system installed in accordance with the applicable edition of NFPA 13?"

### **Answer from CMS:**

*"I spoke to the Atlanta RO about this and they were aware of this and have told TN that it is not a CMS requirement but the State insists that it is a building code requirement and that is how they are citing it. States can have a more stringent requirement although this one is bit much and pretty costly too. I have asked our leadership where we want to go with your request. I should know in a day or so what we want to do."*

From:

James Merrill  
DEPARTMENT OF HEALTH  
& HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850  
410-786-6998  
James.Merrill@cms.hhs.gov

## **II. State AHJ – Question and Responses**

### **Question to State AHJ**

The following question was sent to several state agencies that regulate nursing home construction around Tennessee.

"In a single existing or new nursing home under 52,000 SQ. FT. and under one roof/owner that has multiple fire areas separated by 4 hour fire rated (or 3 or 2 hour fire rated as now permitted by IBC) Fire Walls, would you allow the building to be supplied by a single sprinkler riser and allow the interior sprinkler piping to penetrate the 4 hour fire rated (or 3 or 2 hour fire rated as now permitted by IBC) Fire Walls if the penetrations were properly protected and the sprinkler system was installed in accordance with the applicable edition of NFPA 13?"

The following answers are from the various jurisdictional authorities that regulate the design and construction of nursing homes.

**Responses from State AHJ**

**Alabama: YES**

Vic Hunt, Director  
Office of Facilities Management  
The Alabama Department of Public Health  
The RSA Tower, Suite 1550  
PO Box 303017  
Montgomery, AL 36130-3017  
Phone 334-206-5218  
[victor.hunt@adph.state.al.us](mailto:victor.hunt@adph.state.al.us)

*Comment: Our practice will typically be to show the number of the code paragraph that a facility is not complying with. If you can't do that, you are likely to enforce your opinions, good ideas and bad ideas. Philosophically, when a jurisdiction adopts a code to be enforced, the jurisdiction's employees don't have the authority to enforce their ideas and opinions.*

**Arkansas: YES**

Paul Acre, PE  
Manager Health Facilities  
Arkansas Department of Health  
4815 West Markham Street  
Little Rock, Arkansas 72205  
501-661-2201  
[paul.acre@arkansas.gov](mailto:paul.acre@arkansas.gov)

*Comment: To answer your statement/question, we would not have any issues with penetration of Fire Barriers, Fire Barrier Walls, or even Fire Walls, unless they were Party Walls, regardless of the rating.*

**Florida: YES**

Wayne Young, AIA  
Bureau Chief  
Office of Plans and Construction  
Agency for Health Care Administration  
Tallahassee, Florida 32303  
850-412-4470  
[wayne.young@AHCA.myflorida.com](mailto:wayne.young@AHCA.myflorida.com)

**Comment: None**

**Texas: YES**

Fred Worley, Architect  
Architectural Unit Manager  
Survey Operations Section  
Regulatory Services Division  
Texas Department of Aging and Disability Services  
512-438-2311  
[fred.worley@dads.state.tx.us](mailto:fred.worley@dads.state.tx.us)

Comment: NFPA 13 system protection areas limit systems with single risers to 52,000 square feet. NFPA 101 penetrations and miscellaneous openings in fire barriers must be protected with materials or devices capable of maintaining the fire resistance of the fire barrier. Texas DADS would approve the single system riser with sprinkler pipe penetrations through four-hour walls for a nursing facility.

**Virginia: YES**

Ed Altizer, P. E.  
State Fire Marshal  
State Fire Marshal's Office  
VA Department of Fire Programs  
1005 Technology Park Drive  
Glen Allen, Virginia 23059  
804-612-7267  
[ed.altizer@vdfp.virginia.gov](mailto:ed.altizer@vdfp.virginia.gov)

Comment: *In response to your question, the Virginia SFMO in applying the Life Safety Code to health care buildings would be guided by Section 8.2.4 of NFPA 13- 2013.*

*8.2.4 Multiple buildings attached by canopies, covered breezeways, common roofs, or a common wall(s) shall be permitted to be supplied by a single fire sprinkler riser.*

*I think this clearly defines that two buildings or portions of one building may be supplied from one riser if their combined areas do not exceed the maximum square footage allowance. This is our interpretation of the code and we would be guided by it for both new and retrofit installations even though CMS uses the 2000 LSC. Editions of NFPA 13 prior to the 2007 edition did not include the above language. However, I have been guided by that intent for many years.*

*I also must point out that our state code also must be considered. As you know, the Virginia Uniform Statewide Building Code (USBC) applies to all new and retrofit construction in Virginia. I would point out that Section 706.1.1 of the USBC would not allow penetrations of a party wall except for mall buildings. I do not believe this would be an issue in the LSC though.*

*In answer to your question, the bottom line is that we would not require a separate riser for those health care buildings subject to the LSC and under one roof, attached by a common wall, or connected by breezeways or canopies. We would also advise that NFPA 13 would permit a single riser not to exceed the maximum per floor area specified in NFPA 13. I*

*would also opine that the Virginia Building and Fire Codes would not require a separate riser unless the maximum floor areas are exceeded or a party wall is breached. The rating of the wall is not an issue only if it is a party wall, so a 4 hour fire wall would also be OK. However, again I would point out that the Building Official may have a different opinion.*

*FYI Claude Hutton copied above is an engineer with the SFMO and has extensive sprinkler experience. I asked him to look at what I have said just to see if I have missed anything. He pointed out the USBC party wall requirement and researched other items along with me. We wanted to make sure we did not miss anything.*

**Georgia: YES**

Dwayne Garriss  
State Fire Marshall  
Office of State Fire Marshal  
Office of Regulatory Services  
Georgia Department of Regulatory Services  
2 Martin Luther King Drive, 7<sup>th</sup> Floor West  
Tower, Room 916  
Atlanta, Georgia 30334  
404-657-1168 Email: dgarriss@sfm.ga.gov

Comment: Based on discussions with Mr. Garriss by Thomas Jaeger, Georgia allows a single riser to supply multiple fire areas in a single building that is installed in accordance with NFPA 13 and allows sprinkler piping to penetrate fire walls, other than party walls, to include 4 hour rated fire walls. See attached letter sent to Mr. Jaeger.

**Mississippi: YES**

Dwayne Madison, Director  
Div. of Health Facilities  
Fire Safety and Construction  
Mississippi State Dept of Health  
P.O. Box 1700  
Jackson, Mississippi 39215  
601-364-1111 Email: Dwayne.madison@msdh.state.ms.us

Comment: *To the question: "In a single existing or new nursing home under 52K ft<sup>2</sup> under one roof/owner that has multiple fire areas separated by 4 hour fire walls would CMS allow the building to be supplied by a single sprinkler riser and allow the interior sprinkler piping to penetrate the 4 hour fire walls if the penetrations were properly protected and the sprinkler system installed in accordance with the applicable edition of NFPA 13?"*) I can, with complete confidence, respond with the statement below.

*Based on a 22 year application of CMS life and fire safety requirements, I find nothing under the jurisdiction of the Mississippi State Department of Health, Bureau of Health Facilities Licensure and Certification, or CMS, that precludes penetration of a four-hour, fire rated separation by fire sprinkler piping notwithstanding the qualifiers for such an action as mentioned in your query. Also, please accept this as attestation that no record of such action was ever suggested, proposed, ordered, or enforced in Mississippi.*



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Board for Licensing Health Care Facilities

PM81

Policy Memorandum

SUBJECT: Unexpected Loss of Nursing Home Administrator

DATE: April 5, 2022

POLICY: To align with revised Nursing Home Administrator regulations, this policy allows the Board to waive the requirement for a Tennessee licensed nursing home administrator for a period of six (6) months to coincide with scheduled Board meetings, if one of the following guidelines are met for a temporary nurse home administrator:

- A full-time administrator licensed in Tennessee or any other state;
- One or more part-time administrators licensed in Tennessee, employed no less than 20 hours per week;
- A full-time candidate for licensure as a Tennessee administrator who has completed the required training;
- If temporary administrator seeking nursing home administrator licensure in Tennessee, is eligible for Tennessee Nursing Home Administrator licensure and date of BENHA Board presentation.

A facility's application for waiver shall include the number for licensed beds, the date of the last day of employment of previous administrator, date of hire and name of temporary administrator, if the temporary administrator will become the permanent administrator, list of states in which the temporary administrator has a nursing home administrator's license with its status, and any information required by the Board. The Board will assess the circumstances and may grant, refuse, or condition a waiver as necessary to protect the health, safety, and welfare of the patients in the facility. If the temporary administrator were to change, notice must be made to the Board for Licensing Health Care Facilities within thirty (30) days.

EFFECTIVE: April 5, 2022

APPROVED:

Rene Saunders, M.D., Chairman  
Board for Licensing Health Care Facilities

Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities



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PM 82

Board for Licensing Health Care Facilities

Policy Memorandum

**SUBJECT: INTERPRETATION AND TEMPORARY WAIVER OF RULES  
RELATED TO TREATMENT AND CONTAINMENT OF COVID-19**

**DATE: MARCH 13, 2020**

**POLICY: 82 AMENDED**

**EFFECTIVE: MARCH 13, 2020**  
**\*APRIL 1, 2020**  
**\*SEPTEMBER 8, 2020**  
**\*OCTOBER 7, 2020**  
**\*DECEMBER 17, 2020**  
**\*FEBRUARY 3, 2021**  
**\*JUNE 2, 2021**  
**\*OCTOBER 5, 2021**

**APPROVED: MARCH 13, 2020**  
APRIL 1, 2020  
SEPTEMBER 8, 2020  
OCTOBER 7, 2020  
DECEMBER 17, 2020  
FEBRUARY 3, 2021  
JUNE 2, 2021  
OCTOBER 5, 2021

The Board updates this policy to facilitate the treatment and containment of COVID-19 and to provide consistency with recently updated Tennessee Department of Health (TDH) and Centers for Medicare and Medicaid Services (CMS) guidance as well as the expiration of Governor Bill Lee's Executive Order No. 77, which expired on May 31, 2021. See Attachment A. Effective February 28, 2021, the Tennessee Department of Health lifted all of its state specific restrictions regarding visitation, activities, and dining in long term care facilities.

The Board interprets its rules related to maintaining patient and resident safety as requiring that all licensed facility types, both federally certified and state-licensed only facilities, appropriately screen and monitor patients, residents, staff, and visitors for any symptoms of COVID-19 using the most up to date guidance from The Centers for Disease Control and Prevention (CDC).guidance found at See Attachment B.

On April 27, 2021, CMS updated its August 26, 2020 policy memo entitled “Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Related to Long Term Care (LTC) Facility Requirements and COVID-19 Focused Survey Tool”, QSO-20-38-NH, which implemented CMS’ rule on testing. <https://www.cms.gov/files/document/qso-20-38-nh.pdf>

The QSO also provides regulatory guidance on the requirements of the CMS rule, including frequency of the testing, testing in light of community spread, testing for outbreaks, and testing of symptomatic individuals. CMS QSO-20-38-NH shall be followed regarding testing of patients/residents for COVID-19 in CMS skilled nursing facilities/nursing facilities. See Attachment C.

On April 27, 2021, CMS also revised its September 17, 2020 policy memo entitled “Nursing Home Visitation – COVID-19,” QSO-20-39-NH, updating its visitation guidance in CMS skilled nursing facilities/nursing facilities. *See Attachment D.* CMS QSO-20-39 NH shall be followed regarding visitation of patients/residents during the COVID-19 pandemic in CMS skilled nursing facilities/nursing facilities.

All federally certified facility types are to follow CMS guidance.

When staffing shortages are occurring, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies, in accordance with CDC guidance, to continue to provide patient care.

When there are no longer enough staff to provide safe patient care:

- Implement regional plans to transfer patients with COVID-19 to [designated healthcare facilities](#), or [alternate care sites](#) with adequate staffing
- Allow asymptomatic HCP who are not fully vaccinated and have had a higher-risk exposure to SARS-CoV-2 but are not known to be infected to continue to work onsite throughout their 14-day post-exposure period.
- If permitted to work, these HCP should be monitored for symptoms. If shortages continue despite other mitigation strategies, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 who are asymptomatic willing to work, but have not met all CDC [Return to Work Criteria](#)<sup>1</sup> to work. If HCP are allowed to work before meeting all criteria, facilities should consider prioritizing their duties in the following order:
  - If not already done, allow HCP with suspected or confirmed SARS-CoV-2 infection to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
  - Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with confirmed SARS-CoV-2 infection, preferably in a cohort setting.

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<sup>1</sup> Return to Work Criteria for Healthcare Personnel Infected with SARS-CoV-2 Infection (Interim Guidance); updated February 26, 2021: [www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html](http://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html)

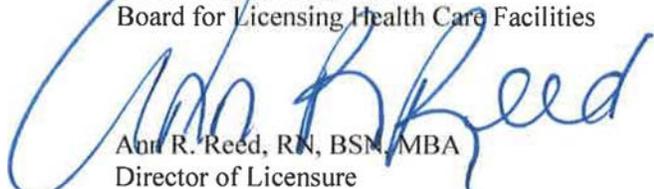
- Allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients with suspected SARS-CoV-2 infection.
- As a last resort, allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients without suspected or confirmed SARS-CoV-2 infection. If this is being considered, this should be used only as a bridge to longer term strategies that do not involve care of uninfected patients by potentially infectious HCP and strict adherence to all other recommended infection prevention and control measures (e.g., use of respirator or well-fitting facemask for source control) is essential. If HCP are permitted to return to work before meeting all [Return to Work criteria](#), they should still adhere to all [Return to Work Practices and Work Restrictions](#) recommendations described in that guidance. These include:

- o Wear an N-95 facemask for source control at all times while in the healthcare facility until they meet the full [Return to Work criteria](#) and all symptoms are completely resolved or at baseline. After this time period, these HCP should revert to their facility policy regarding [universal source control](#) during the pandemic.
  - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
- o They should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
  - Facemasks should be worn even when they are in non-patient care areas such as breakrooms.
  - If they must remove their facemask, for example, in order to eat or drink, they should separate themselves from others by at least six (6) feet.
- o They should self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.
- o NOTE: A facility cannot require a COVID-19 positive HCP to report for duty.

Finally, to allow for the construction of temporary structures related to the treatment and containment of COVID-19, the Board interprets its building standards to include the provisions in Attachment E - COVID-19 Facility Requirements - Temporary Structures.

This policy shall remain in effect until the Board's June 2022 Board Meeting or at an earlier date as determined by the Board.

  
 Dr. Rene Saunders, Chair  
 Board for Licensing Health Care Facilities

  
 Ann R. Reed, RN, BSN, MBA  
 Director of Licensure  
 Board for Licensing Health Care Facilities

Attachments:

- Attachment A Executive Order No. 77, issued February 26, 2020; Executive Order No. 80, issued April 27, 2021
- Attachment B Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes; Updated March 29, 2021
- Attachment C CMS QSO-20-38-NH - Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long Term Care (LTC) Facility requirements and COVID-19 Focused Survey Tool; updated April 27, 2021
- Attachment D CMS QSO-20-39 NH – Nursing Home Visitation – COVID-19; updated April 27, 2021
- Attachment E COVID 19 Facility Requirements – Temporary Structures



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PM 82

Board for Licensing Health Care Facilities

Policy Memorandum

**SUBJECT: INTERPRETATION AND TEMPORARY WAIVER OF RULES  
RELATED TO TREATMENT AND CONTAINMENT OF COVID-19**

**DATE: MARCH 13, 2020**

**POLICY: 82 AMENDED**

**EFFECTIVE: MARCH 13, 2020**  
**\*APRIL 1, 2020**  
**\*SEPTEMBER 8, 2020**  
**\*OCTOBER 7, 2020**  
**\*DECEMBER 17, 2020**  
**\*FEBRUARY 3, 2021**  
**\*JUNE 2, 2021**

**APPROVED: MARCH 13, 2020**  
APRIL 1, 2020  
SEPTEMBER 8, 2020  
OCTOBER 7, 2020  
DECEMBER 17, 2020  
FEBRUARY 3, 2021  
JUNE 2, 2021

The Board updates this policy to facilitate the treatment and containment of COVID-19 and to provide consistency with recently updated Tennessee Department of Health (TDH) and Centers for Medicare and Medicaid Services (CMS) guidance as well as the expiration of Governor Bill Lee's Executive Order No. 77, which expired on May 31, 2021. See Attachment A. Effective February 28, 2021, the Tennessee Department of Health lifted all of its state specific restrictions regarding visitation, activities, and dining in long term care facilities.

The Board interprets its rules related to maintaining patient and resident safety as requiring that all licensed facility types, both federally certified and state-licensed only facilities, appropriately screen and monitor patients, residents, staff, and visitors for any symptoms of COVID-19 using the most up to date guidance from The Centers for Disease Control and Prevention (CDC).guidance found at See Attachment B.

On April 27, 2021, CMS updated its August 26, 2020 policy memo entitled “Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Related to Long Term Care (LTC) Facility Requirements and COVID-19 Focused Survey Tool”, QSO-20-38-NH, which implemented CMS’ rule on testing. <https://www.cms.gov/files/document/qso-20-38-nh.pdf>

The QSO also provides regulatory guidance on the requirements of the CMS rule, including frequency of the testing, testing in light of community spread, testing for outbreaks, and testing of symptomatic individuals. CMS QSO-20-38-NH shall be followed regarding testing of patients/residents for COVID-19 in CMS skilled nursing facilities/nursing facilities. See Attachment C.

On April 27, 2021, CMS also revised its September 17, 2020 policy memo entitled “Nursing Home Visitation – COVID-19,” QSO-20-39-NH, updating its visitation guidance in CMS skilled nursing facilities/nursing facilities. *See* Attachment D. CMS QSO-20-39 NH shall be followed regarding visitation of patients/residents during the COVID-19 pandemic in CMS skilled nursing facilities/nursing facilities.

All federally certified facility types are to follow CMS guidance.

When staffing shortages are occurring, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies, in accordance with CDC guidance, to continue to provide patient care.

When there are no longer enough staff to provide safe patient care:

- Implement regional plans to transfer patients with COVID-19 to designated healthcare facilities, or alternate care sites with adequate staffing
- Allow asymptomatic HCP who are not fully vaccinated and have had a higher-risk exposure to SARS-CoV-2 but are not known to be infected to continue to work onsite throughout their 14-day post-exposure period.
- If permitted to work, these HCP should be monitored for symptoms. If shortages continue despite other mitigation strategies, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 who are asymptomatic willing to work, but have not met all CDC Return to Work Criteria<sup>1</sup> to work. If HCP are allowed to work before meeting all criteria, facilities should consider prioritizing their duties in the following order:
  - If not already done, allow HCP with suspected or confirmed SARS-CoV-2 infection to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
  - Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with confirmed SARS-CoV-2 infection, preferably in a cohort setting.

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<sup>1</sup> Return to Work Criteria for Healthcare Personnel Infected with SARS-CoV-2 Infection (Interim Guidance); updated February 26, 2021: [www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html](http://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html)

- Allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients with suspected SARS-CoV-2 infection.
- As a last resort, allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients without suspected or confirmed SARS-CoV-2 infection. If this is being considered, this should be used only as a bridge to longer term strategies that do not involve care of uninfected patients by potentially infectious HCP and strict adherence to all other recommended infection prevention and control measures (e.g., use of respirator or well-fitting facemask for source control) is essential. If HCP are permitted to return to work before meeting all Return to Work Criteria, they should still adhere to all Return to Work Practices and Work Restrictions recommendations described in that guidance. These include:

- Wear an N-95 facemask for source control at all times while in the healthcare facility until they meet the full Return to Work Criteria and all symptoms are completely resolved or at baseline. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
  - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
- They should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
  - Facemasks should be worn even when they are in non-patient care areas such as breakrooms.
  - If they must remove their facemask, for example, in order to eat or drink, they should separate themselves from others by at least six (6) feet.
- They should self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.
- NOTE: A facility cannot require a COVID-19 positive HCP to report for duty.

Finally, to allow for the construction of temporary structures related to the treatment and containment of COVID-19, the Board interprets its building standards to include the provisions in Attachment E – COVID-19 Facility Requirements – Temporary Structures.

This policy shall remain in effect until the Board's October 2021 Board Meeting or at an earlier date as determined by the Board.



Dr. Rene Saunders, Chair  
Board for Licensing Health Care Facilities



Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities

Attachments:

- Attachment A Executive Order No. 77, issued February 26, 2020; Executive Order No. 80, issued April 27, 2021
- Attachment B Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes; Updated March 29, 2021
- Attachment C CMS QSO-20-38-NH - Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long Term Care (LTC) Facility requirements and COVID-19 Focused Survey Tool; updated April 27, 2021
- Attachment D CMS QSO-20-39 NH – Nursing Home Visitation – COVID-19; updated April 27, 2021
- Attachment E COVID 19 Facility Requirements – Temporary Structures



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Board for Licensing Health Care Facilities

Policy Memorandum

**SUBJECT: INTERPRETATION AND TEMPORARY WAIVER OF RULES  
RELATED TO TREATMENT AND CONTAINMENT OF COVID-19**

**DATE: MARCH 13, 2020**

**POLICY: 82 AMENDED**

**EFFECTIVE: MARCH 13, 2020  
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**APPROVED: MARCH 13, 2020  
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DECEMBER 17, 2020  
FEBRUARY 3, 2021**

The Board issues this policy to facilitate the treatment and containment of COVID-19. With this same aim, on March 12, 2020, Tennessee Governor, Bill Lee, issued Executive Order No. 14, which suspends certain statutes and rules. See Attachment A. In letters dated March 4, 2020, March 9, 2020, and March 10, 2020, the Centers for Medicare and Medicaid (CMS) suspended certain survey activities and issued guidance for the following federally certified facility types: hospitals, hospices, end stage renal dialysis (ESRD) treatment facilities, home health agencies, and nursing homes. See Attachments D through J.

The Board interprets its rules related to maintaining patient and resident safety as requiring that all licensed facility types appropriately screen and monitor patients, residents, staff, and visitors for any symptoms of COVID-19. The Centers for Disease Control and Prevention (CDC) guidance found at <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html> shall be followed for patient/residents, staff, and visitors with known or suspected COVID 19. See Attachment C.

On August 25, 2020, the Centers for Medicare and Medicaid Services (CMS) published an interim final rule entitled “Medicare and Medicaid Programs, Clinical Laboratory Improvement

Amendments of 1988 and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency.” On August 26, 2020, CMS published a policy memo entitled “Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Related to Long Term Care (LTC) Facility Requirements and COVID-19 Focused Survey Tool”, QSO-20-38-NH, implementing the testing rule. <https://www.cms.gov/files/document/qso-20-38-nh.pdf>

The QSO also provides regulatory guidance on the requirements of the CMS rule, including frequency of the testing, testing in light of community spread, testing for outbreaks, and testing of symptomatic individuals. CMS QSO-20-38-NH shall be followed regarding testing of patients/residents for COVID-19 in CMS skilled nursing facilities/nursing facilities. See Attachment K.

On or about September 17, 2020, CMS published a policy memo entitled “Nursing Home Visitation – COVID-19,” QSO-20-39-NH, implementing visitation guidance in CMS skilled nursing facilities/nursing facilities. *See Attachment L.* CMS QSO-20-39 NH shall be followed regarding visitation of patients/residents during the COVID-19 pandemic in CMS skilled nursing facilities/nursing facilities.

All federally certified facility types are to follow CMS guidance.

On or about September 17, 2020, the Tennessee Department of Health published COVID-19 LTCF Visitation Guidelines and LTCF Activities & Dining Guidelines. *See Attachments M & N.* Assisted care living facilities and residential homes for the aged shall comply the Department of Health’s LTCF Visitation Guidelines and LTCF Activities & Dining Guidelines.

When staffing shortages are occurring, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care.

When there are no longer enough staff to provide safe patient care:

- Implement regional plans to transfer patients with COVID-19 to designated healthcare facilities, or alternate care sites with adequate staffing
- If not already done, implement plans (see contingency capacity strategies above) to allow asymptomatic health care providers (“HCP”) who have had exposure to SARS-CoV-2 but are not known to be infected to continue to work.
  - If HCP are tested and found to be infected with SARS-CoV-2, they should be excluded from work until they meet all CDC Return to Work Criteria<sup>1</sup> (unless they are allowed to work as described below).
- If shortages continue despite other mitigation strategies, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 who are asymptomatic willing to work, but have not met all CDC Return to Work Criteria to work. If HCP are allowed to work before meeting all criteria, facilities should consider prioritizing their duties in the following order:

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<sup>1</sup> Return-to-Work Criteria for Healthcare Workers | CDC

1. If not already done, allow HCP with suspected or confirmed COVID-19 to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
2. Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.

If HCP are permitted to return to work before meeting all [Return to Work Criteria](#), they should still adhere to all [Return to Work Practices and Work Restrictions](#) recommendations described in that guidance. These include:

- Wear an N-95 facemask for source control at all times while in the healthcare facility until they meet the full [Return to Work Criteria](#) and all symptoms are completely resolved or at baseline. After this time period, these HCP should revert to their facility policy regarding [universal source control](#) during the pandemic.
  - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
- They should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
  - Facemasks should be worn even when they are in non-patient care areas such as breakrooms.
  - If they must remove their facemask, for example, in order to eat or drink, they should separate themselves from others by at least six (6) feet.
- They should self-monitor for symptoms and seeking re-evaluation from occupational health if respiratory symptoms recur or worsen.
- NOTE: A facility cannot involuntarily require a COVID-19 positive HCP to report for duty.

Finally, to allow for the construction of temporary structures related to the treatment and containment of COVID-19, the Board interprets its building standards to include the provisions in Attachment B – COVID-19 Facility Requirements – Temporary Structures.

This policy shall remain in effect until the Board's June 2021 Board Meeting or at an earlier date as determined by the Board.



Dr. Rene Saunders, Chair  
Board for Licensing Health Care Facilities



Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities

Attachments:

Attachment A	Executive Order No. 14, Issues March 12, 2020
Attachment B	COVID-19 Facility Requirements – Temporary Structures
Attachment C	March 11, 2020 TDH Commissioner Memo to LTC Facilities
Attachment D-J	CMS Letters Providing Guidance to Federally Certified Facilities
Attachment K	CMS QSO-20-38-NH - Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long Term Care (LTC) Facility requirements and COVID-19 Focused Survey Tool.
Attachment L	CMS QSO-20-39 NH – Nursing Home Visitation – COVID-19
Attachment M	Tennessee Department of Health, LTCF Visitation Guidelines
Attachment N	Tennessee Department of Health, LTCF Activities & Dining Guidelines



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Policy Memorandum

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**DATE: MARCH 13, 2020**

**POLICY: 82 AMENDED**

**EFFECTIVE: MARCH 13, 2020  
\*APRIL 1, 2020  
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**APPROVED: MARCH 13, 2020  
APRIL 1, 2020  
SEPTEMBER 8, 2020  
OCTOBER 7, 2020  
DECEMBER 17, 2020**

The Board issues this policy to facilitate the treatment and containment of COVID-19. With this same aim, on March 12, 2020, Tennessee Governor, Bill Lee, issued Executive Order No. 14, which suspends certain statutes and rules. See Attachment A. In letters dated March 4, 2020, March 9, 2020, and March 10, 2020, the Centers for Medicare and Medicaid (CMS) suspended certain survey activities and issued guidance for the following federally certified facility types: hospitals, hospices, end stage renal dialysis (ESRD) treatment facilities, home health agencies, and nursing homes. See Attachments D through J.

The Board interprets its rules related to maintaining patient and resident safety as requiring that all licensed facility types appropriately screen and monitor patients, residents, staff, and visitors for any symptoms of COVID-19. The Centers for Disease Control and Prevention (CDC) guidance found at <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html> shall be followed for patient/residents, staff, and visitors with known or suspected COVID 19. See Attachment C.

On August 25, 2020, the Centers for Medicare and Medicaid Services (CMS) published an interim final rule entitled "Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments of 1988 and Patient Protection and Affordable Care Act; Additional Policy and

Regulatory Revisions in Response to the COVID-19 Public Health Emergency.” On August 26, 2020, CMS published a policy memo entitled “Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Related to Long Term Care (LTC) Facility Requirements and COVID-19 Focused Survey Tool”, QSO-20-38-NH, implementing the testing rule. <https://www.cms.gov/files/document/qso-20-38-nh.pdf>

The QSO also provides regulatory guidance on the requirements of the CMS rule, including frequency of the testing, testing in light of community spread, testing for outbreaks, and testing of symptomatic individuals. CMS QSO-20-38-NH shall be followed regarding testing of patients/residents for COVID-19 in CMS skilled nursing facilities/nursing facilities. See Attachment K.

On or about September 17, 2020, CMS published a policy memo entitled “Nursing Home Visitation – COVID-19,” QSO-20-39-NH, implementing visitation guidance in CMS skilled nursing facilities/nursing facilities. *See Attachment L.* CMS QSO-20-39 NH shall be followed regarding visitation of patients/residents during the COVID-19 pandemic in CMS skilled nursing facilities/nursing facilities.

All federally certified facility types are to follow CMS guidance.

On or about September 17, 2020, the Tennessee Department of Health published COVID-19 LTCF Visitation Guidelines and LTCF Activities & Dining Guidelines. *See Attachments M & N.* Assisted care living facilities and residential homes for the aged shall comply the Department of Health’s LTCF Visitation Guidelines and LTCF Activities & Dining Guidelines.

When staffing shortages are occurring, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care.

When there are no longer enough staff to provide safe patient care:

- Implement regional plans to transfer patients with COVID-19 to designated healthcare facilities, or alternate care sites with adequate staffing
- If not already done, implement plans (see contingency capacity strategies above) to allow asymptomatic health care providers (“HCP”) who have had exposure to SARS-CoV-2 but are not known to be infected to continue to work.
  - If HCP are tested and found to be infected with SARS-CoV-2, they should be excluded from work until they meet all CDC Return to Work Criteria<sup>1</sup> (unless they are allowed to work as described below).
- If shortages continue despite other mitigation strategies, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 who are asymptomatic willing to work, but have not met all CDC Return to Work Criteria to work. If HCP are allowed to work before meeting all criteria, facilities should consider prioritizing their duties in the following order:

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<sup>1</sup> [Return-to-Work Criteria for Healthcare Workers | CDC](#)

1. If not already done, allow HCP with suspected or confirmed COVID-19 to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
2. Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.

If HCP are permitted to return to work before meeting all [Return to Work Criteria](#), they should still adhere to all [Return to Work Practices and Work Restrictions](#) recommendations described in that guidance. These include:

- Wear an N-95 facemask for source control at all times while in the healthcare facility until they meet the full [Return to Work Criteria](#) and all symptoms are completely resolved or at baseline. After this time period, these HCP should revert to their facility policy regarding [universal source control](#) during the pandemic.
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- They should self-monitor for symptoms and seeking re-evaluation from occupational health if respiratory symptoms recur or worsen.
- NOTE: A facility cannot involuntarily require a COVID-19 positive HCP to report for duty.

Finally, to allow for the construction of temporary structures related to the treatment and containment of COVID-19, the Board interprets its building standards to include the provisions in Attachment B – COVID-19 Facility Requirements – Temporary Structures.

This policy shall remain in effect until the Board's February 2021 Board Meeting or at an earlier date as determined by the Board.



Dr. Rene Saunders, Chair  
Board for Licensing Health Care Facilities



Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities

**Attachments:**

- Attachment A** Executive Order No. 14, Issues March 12, 2020
- Attachment B** COVID-19 Facility Requirements – Temporary Structures
- Attachment C** March 11, 2020 TDH Commissioner Memo to LTC Facilities
- Attachment D-J** CMS Letters Providing Guidance to Federally Certified Facilities
- Attachment K** CMS QSO-20-38-NH - Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long Term Care (LTC) Facility requirements and COVID-19 Focused Survey Tool.
- Attachment L** CMS QSO-20-39 NH – Nursing Home Visitation – COVID-19
- Attachment M** Tennessee Department of Health, LTCF Visitation Guidelines
- Attachment N** Tennessee Department of Health, LTCF Activities & Dining Guidelines



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**DATE: MARCH 13, 2020**

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The Board interprets its rules related to maintaining patient and resident safety as requiring that all licensed facility types appropriately screen and monitor patients, residents, staff, and visitors for any symptoms of COVID-19. The Centers for Disease Control and Prevention (CDC) guidance found at <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html> shall be followed for patient/residents, staff, and visitors with known or suspected COVID 19. See Attachment C.

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2020, CMS published a policy memo entitled “Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Related to Long Term Care (LTC) Facility Requirements and COVID-19 Focused Survey Tool”, QSO-20-38-NH, implementing the testing rule. <https://www.cms.gov/files/document/qso-20-38-nh.pdf>

The QSO also provides regulatory guidance on the requirements of the CMS rule, including frequency of the testing, testing in light of community spread, testing for outbreaks, and testing of symptomatic individuals. CMS QSO-20-38-NH shall be followed regarding testing of patients/residents for COVID-19 in CMS skilled nursing facilities/nursing facilities. See Attachment K.

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All federally certified facility types are to follow CMS guidance.

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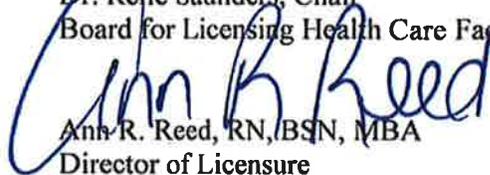
COVID-19 is excluded from Tenn. Comp. R. & Reg. 1200-08-25-.06(5)(a) and Tenn. Comp. R. & Reg. 1200-08-11-.04(7) which allow ACLFs and RHAs, respectively, to allow employees with a reportable communicable disease to continue to work in the facility if there is a written protocol in place and approved by the Board’s administrative office. Workers with known or suspected COVID-19 shall not report to work.

Finally, to allow for the construction of temporary structures related to the treatment and containment of COVID-19, the Board interprets its building standards to include the provisions in Attachment B – COVID-19 Facility Requirements – Temporary Structures.

This policy shall remain in effect until the Board’s February 2021 Board Meeting or at an earlier date as determined by the Board.



Dr. Rene Saunders, Chair  
Board for Licensing Health Care Facilities



Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities

**Attachments:**

- Attachment A** Executive Order No. 14, Issues March 12, 2020
- Attachment B** COVID-19 Facility Requirements – Temporary Structures
- Attachment C** March 11, 2020 TDH Commissioner Memo to LTC Facilities
- Attachment D-J** CMS Letters Providing Guidance to Federally Certified Facilities
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Survey Tool”, QSO-20-38-NH, implementing the testing rule.  
<https://www.cms.gov/files/document/qso-20-38-nh.pdf>

The QSO also provides regulatory guidance on the requirements of the CMS rule, including frequency of the testing, testing in light of community spread, testing for outbreaks, and testing of symptomatic individuals. CMS QSO-20-38-NH shall be followed regarding testing of patients/residents for COVID-19 in CMS skilled nursing facilities/nursing facilities. See Attachment K.

Licensed facilities with policies or plans in place regarding the restriction or limitation of visitation will be held to those policies or plans. The following rules are hereby suspended in order to allow these facilities types to restrict or limit visitation in order to protect residents from the spread of COVID-19:

Assisted Care Living Facilities (ACLF)	Tenn. Comp. R. & Reg. 1200-08-25-.14(1)(o)
Residential Homes for the Aged (RHA)	Tenn. Comp. R. & Reg. 1200-08-11-.11(15)
Traumatic Brain Injury Residential Homes	Tenn. Comp. R. & Reg. 1200-08-37-.15(o)
Adult Care Homes	Tenn. Comp. R. & Reg. 1200-08-36-.15(o)
HIV Supportive Living Centers	Tenn. Comp. R. & Reg. 1200-08-28-.12(e)

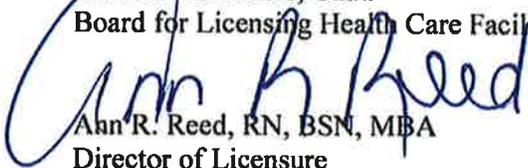
All federally certified facility types are to follow CMS guidance.

COVID-19 is excluded from Tenn. Comp. R. & Reg. 1200-08-25-.06(5)(a) and Tenn. Comp. R. & Reg. 1200-08-11-.04(7) which allow ACLFs and RHAs, respectively, to allow employees with a reportable communicable disease to continue to work in the facility if there is a written protocol in place and approved by the Board’s administrative office. Workers with known or suspected COVID-19 shall not report to work.

Finally, to allow for the construction of temporary structures related to the treatment and containment of COVID-19, the Board interprets its building standards to include the provisions in Attachment B – COVID-19 Facility Requirements – Temporary Structures.

This policy shall remain in effect until October 7, 2020 or at an earlier date as determined by the Board.

  
Dr. Rene Saunders, Chair  
Board for Licensing Health Care Facilities

  
Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities

**Attachments:**

Attachment A	Executive Order No. 14, Issues March 12, 2020
Attachment B	COVID-19 Facility Requirements – Temporary Structures
Attachment C	March 11, 2020 TDH Commissioner Memo to LTC Facilities
Attachment D-J	CMS Letters Providing Guidance to Federally Certified Facilities
Attachment K	CMS QSO-20-38-NH - Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long Term Care (LTC) Facility requirements and COVID-19 Focused Survey Tool.



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
DIVISION OF HEALTH LICENSURE & REGULATION  
OFFICE OF HEALTH CARE FACILITIES  
665 MAINSTREAM DRIVE, SECOND FLOOR  
NASHVILLE, TENNESSEE 37243  
TELEPHONE (615) 741-7221  
FAX (615) 741-7051

PM 82 AMENDED

Board for Licensing Health Care Facilities

Policy Memorandum

**SUBJECT: INTERPRETATION AND TEMPORARY WAIVER OF RULES  
RELATED TO TREATMENT AND CONTAINMENT OF COVID-19**

**DATE: MARCH 13, 2020**

**POLICY: 82 AMENDED**

**EFFECTIVE: MARCH 13, 2020  
\* APRIL 1, 2020**

**APPROVED: MARCH 13, 2020  
\* APRIL 1, 2020**

The Board issues this policy to facilitate the treatment and containment of COVID-19. With this same aim, on March 12, 2020, Tennessee Governor, Bill Lee, issued Executive Order No. 14, which suspends certain statutes and rules. See Attachment A. In letters dated March 4, 2020, March 9, 2020, and March 10, 2020, the Centers for Medicare and Medicaid (CMS) suspended certain survey activities and issued guidance for the following federally certified facility types: hospitals, hospices, end stage renal dialysis (ESRD) treatment facilities, home health agencies, and nursing homes. See Attachments D through J.

The Board interprets its rules related to maintaining patient and resident safety as requiring that all licensed facility types appropriately screen and monitor patients, residents, staff, and visitors for any symptoms of COVID-19. The Centers for Disease Control and Prevention (CDC) guidance found at <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html> shall be followed for patient/residents, staff, and visitors with known or suspected COVID 19. See Attachment C.

Licensed facilities with policies or plans in place regarding the restriction or limitation of visitation will be held to those policies or plans. The following rules are hereby suspended in order to allow these facilities types to restrict or limit visitation in order to protect residents from the spread of COVID-19:

Assisted Care Living Facilities (ACLF)	Tenn. Comp. R. & Reg. 1200-08-25-.14(1)(o)
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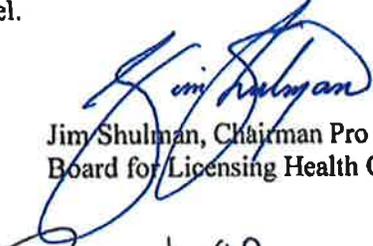
All federally certified facility types are to follow CMS guidance.

COVID-19 is excluded from Tenn. Comp. R. & Reg. 1200-08-25-.06(5)(a) and Tenn. Comp. R. & Reg. 1200-08-11-.04(7) which allow ACLFs and RHAs, respectively, to allow employees with a reportable communicable disease to continue to work in the facility if there is a written protocol in place and approved by the Board's administrative office. Workers with known or suspected COVID-19 shall not report to work.

Finally, to allow for the construction of temporary structures related to the treatment and containment of COVID-19, the Board interprets its building standards to include the provisions in Attachment B – COVID-19 Facility Requirements – Temporary Structures.

This policy shall remain in effect until October 7, 2020 or at an earlier date as determined by the Board.

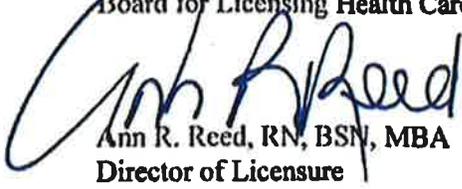
\* Board Policy #82, as it relates to temporary hospital structures, includes (1) use by a hospital of its existing space to provide hospital services in a manner that temporarily varies from FGI guidelines, such as a hospital using single occupancy rooms for semi-private occupancy and (2) use by a hospital of space to provide hospital services temporarily at a location not previously approved for occupancy by the hospital, such as an inpatient rehabilitation facility, a nursing facility or a hotel.



Jim Shulman, Chairman Pro Tem  
Board for Licensing Health Care Facilities



Rene Saunders, M.D., Chairman  
Board for Licensing Health Care Facilities



Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities

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Health

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PM 82

Board for Licensing Health Care Facilities

Policy Memorandum

**SUBJECT: INTERPRETATION AND TEMPORARY WAIVER OF RULES RELATED TO TREATMENT AND CONTAINMENT OF COVID-19**

**DATE: MARCH 13, 2020**

**POLICY: 82**

**EFFECTIVE: MARCH 13, 2020**

**APPROVED: MARCH 13, 2020**

The Board issues this policy to facilitate the treatment and containment of COVID-19. With this same aim, on March 12, 2020, Tennessee Governor, Bill Lee, issued Executive Order No. 14, which suspends certain statutes and rules. See Attachment A. In letters dated March 4, 2020, March 9, 2020, and March 10, 2020, the Centers for Medicare and Medicaid (CMS) suspended certain survey activities and issued guidance for the following federally certified facility types: hospitals, hospices, end stage renal dialysis (ESRD) treatment facilities, home health agencies, and nursing homes. See Attachments D through J.

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- |  |  |
|--|--|
| Assisted Care Living Facilities (ACLF)   | Tenn. Comp. R. & Reg. 1200-08-25-.14(1)(o) |
| Residential Homes for the Aged (RIIA)    | Tenn. Comp. R. & Reg. 1200-08-11-.11(15)   |
| Traumatic Brain Injury Residential Homes | Tenn. Comp. R. & Reg. 1200-08-37-.15(o)    |
| Adult Care Homes                         | Tenn. Comp. R. & Reg. 1200-08-36-.15(o)    |
| HIV Supportive Living Centers            | Tenn. Comp. R. & Reg. 1200-08-28-.12(e)    |

All federally certified facility types are to follow CMS guidance.

COVID-19 is excluded from Tenn. Comp. R. & Reg. 1200-08-25-.06(5)(a) and Tenn. Comp. R. & Reg. 1200-08-11-.04(7) which allow ACLFs and RHAs, respectively, to allow employees with a reportable communicable disease to continue to work in the facility if there is a written protocol in place and approved by the Board's administrative office. Workers with known or suspected COVID-19 shall not report to work.

Finally, to allow for the construction of temporary structures related to the treatment and containment of COVID-19, the Board interprets its building standards to include the provisions in Attachment B – COVID-19 Facility Requirements – Temporary Structures.

This policy shall remain in effect until October 7, 2020 or at an earlier date as determined by the Board.

  
Jim Shulman, Chairman Pro Tem  
Board for Licensing Health Care Facilities

  
Ann R. Reed, RN, MSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities

**Attachments:**

Attachment A	Executive Order No. 14, Issues March 12, 2020
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RECEIVED

APR 27 2021

Secretary of State  
Tre Hargett



STATE OF TENNESSEE  
**EXECUTIVE ORDER**  
BY THE GOVERNOR

No. 80

**AN ORDER AMENDING EXECUTIVE ORDER NO. 77**

**WHEREAS**, individuals, businesses, local governments, faith communities, and other entities across the State responded to COVID-19 by changing behaviors and operations to protect our most vulnerable populations while continuing to provide the goods and services necessary to support our communities and our economy; and

**WHEREAS**, our healthcare infrastructure has adapted, and is continuing to adapt pursuant to pending legislation that is anticipated to become law during the remainder of the legislative session, to facilitate the treatment and containment of COVID-19; and

**WHEREAS**, safe and effective COVID-19 vaccines are now readily available for walkup administration without an appointment, and a large number of Tennesseans have already been vaccinated; and

**WHEREAS**, as a result of infrastructure advancements, vaccine availability, and public awareness of best practices to prevent the spread of COVID-19, Tennessee citizens and businesses are empowered to responsibly confront and manage the risks of COVID-19.

**NOW THEREFORE**, I, Bill Lee, Governor of the State of Tennessee, by virtue of the power and authority vested in me by the Tennessee Constitution and other applicable law including Tennessee Code Annotated § 58-2-107, do hereby declare a continuing limited state of emergency and incorporate the provisions of Executive Order No. 77 subject to the amendments herein:

**Executive Order No. 77, Section C**, regarding delegation of local authority for face coverings, is deleted.

**The "Tennessee Pledge"** should no longer be considered an independent source of information or recommendations, recognizing that guidance and information is available and should be sought from traditional public health agencies, and thus all references to the Pledge in Executive Order No. 77 are deleted.

Executive Order No. 77, Section D, Paragraph 3, is hereby amended as follows:

3. Term and effective date. This Order shall remain in effect until 11:59 p.m., Central Time, on May 31, 2021.

**IN WITNESS WHEREOF**, I have subscribed my signature and caused the Great Seal of the State of Tennessee to be affixed this 27<sup>th</sup> day of April, 2021, and hereby order that this Executive Order No. 80 shall go into effect at 11:59 p.m., Central Time, on April 28, 2021.

  
GOVERNOR

ATTEST:

  
SECRETARY OF STATE



RECEIVED

FEB 26 2021

Secretary of State  
Tre Hargett



STATE OF TENNESSEE  
**EXECUTIVE ORDER**  
BY THE GOVERNOR

No. 77

**AN ORDER TO FACILITATE THE CONTINUED RESPONSE TO COVID-19 BY  
EXTENDING EXECUTIVE ORDER NO. 73, AS AMENDED**

**WHEREAS**, ongoing regulatory flexibility and other provisions in Executive Order No. 73, as otherwise amended herein, are required to address the continuing effects, risks, and persistent negative economic conditions in order to assist Tennessee's citizens, health care systems, industries, small businesses, local and state governments, and religious and non-profit institutions combat and recover from the long-term effects of COVID-19; and

**WHEREAS**, given the continuing effects from COVID-19, Tennesseans have a personal responsibility to protect themselves and others by following health guidelines to slow the spread of this virus, and therefore, all venues, employers, businesses, and organizations should be mindful of the guidance issued by the Governor's Economic Recovery Group (i.e., the Tennessee Pledge), which are available at the following web address and may be periodically updated: <https://www.tn.gov/governor/covid-19/economic-recovery.html>; and

**WHEREAS**, in addition to the other powers granted by law, Tennessee Code Annotated, Section 58-2-107, provides, among other things, that during a state of emergency, the Governor is authorized to suspend laws and rules if necessary to cope with an emergency, utilize all available state and local resources needed to combat an emergency, and take measures concerning the conduct of civilians; and

**WHEREAS**, pursuant to this authority and the general emergency management powers of the Governor under law, such measures, including the measures contained herein, are necessary to facilitate the response to the ongoing effects of COVID-19.

**NOW THEREFORE**, I, Bill Lee, Governor of the State of Tennessee, by virtue of the power and authority vested in me by the Tennessee Constitution and other applicable law, do hereby declare a continuing state of emergency and major disaster in order to facilitate the response to COVID-19 and accordingly extend and order the following:

A. Restated provisions that originated in Executive Order No. 36 (as amended in other orders or herein) and similar provisions added in this Order:

1. Activation of Tennessee Emergency Management Plan. The Commissioner of Health or her designee, in conjunction with the Director of the Tennessee Emergency Management Agency (TEMA) or his designee, shall implement the Tennessee Emergency Management Plan (TEMP) and all applicable annexes to coordinate the State's response to COVID-19.
2. Out-of-state health care providers may practice in Tennessee. The relevant provisions of Tennessee Code Annotated, Titles 63 and 68, and related rules are hereby suspended to the extent necessary to give the Commissioner of Health the discretion to allow a health care professional who is licensed in another state, and who would otherwise be subject to the licensing requirements under Title 63 or Title 68, to engage in the practice of such individual's profession in Tennessee, if such individual is a health care professional who is assisting in the medical response to COVID-19, including treating routine or other medical conditions. The Commissioner of Health shall provide the requisite form for practicing under this Paragraph on the Department of Health's Health Professional Boards webpage.
- 7.3 Retired medical professionals can easily reenter the health care workforce. The provisions of Tennessee Code Annotated, Titles 63 and 68, and related rules and policies are hereby suspended to the extent necessary to give the Commissioner of Health the authority to grant a license, certificate, or registration to a health care professional, such as a retired health care professional, who has been out of practice for a period of time without requiring that individual to demonstrate continued competency or submit to an interview before a licensing board or other licensing authority, provided that the individual satisfies all other requirements for licensure, certification, or registration.
- 7.4 In-person and live continuing education requirements are suspended for health care professionals. The provisions of the rules and policies adopted pursuant to Tennessee Code Annotated, Titles 63 and 68, regarding continuing education credits and hours for health care professionals are hereby suspended to the extent necessary to suspend the requirement that any continuing education credits and hours be obtained in-person or at a live event for credit and hours earned from March 12, 2020, through the expiration of this Order. Such rules and policies are further suspended to the extent necessary to allow the Commissioner of Health to adopt policies necessary to comply with the suspension of in-person and live continuing education requirements, and the Commissioner of Health is hereby directed to adopt policies to that effect. Nothing in this provision suspends the requirements that health care professionals obtain a certain number of continuing education credits or hours.
- 7.5 Laboratory inspections are suspended to allow for immediate COVID-19 testing. The provisions of Tenn. Comp. R. & Regs. 1200-06-03-.03(3) and 1200-06-03-

.04(2) are hereby suspended to the extent necessary to give the Commissioner of the Department of Health the authority to suspend any required onsite inspections of laboratories to the extent necessary to allow laboratories to immediately begin testing for COVID-19.

- 7.6 Health care licensing inspections and investigations are suspended to increases resources available to fight COVID-19 and to protect public health. The provisions of Tennessee Code Annotated, Titles 63 and 68, and related rules and policies are hereby suspended to the extent necessary to suspend any requirement that the Department of Health conduct inspections or investigations of a licensee, including, but not limited to, complaint investigations, routine surveys, and site visits. However, the Department of Health retains the authority to conduct any inspection or investigation when, in the Department's sole discretion, the public health, safety, or welfare necessitates such inspection or investigation.
- 7.9 Inspections of health care facilities are suspended. The provisions of Tennessee Code Annotated, Section 68-11-210(a)(1), are hereby suspended to the extent necessary to suspend the requirement that the Department of Health conduct inspections of facilities applying for licensure if the applicant facility is physically located in the same location as another licensed facility where patients have been seen within the thirty (30) days preceding the submission of the application. In instances where the Department of Health elects to not inspect a facility applying for licensure, such provisions requiring a facility applying for licensure to be inspected are hereby suspended.
- 7.10 Inspections of medical laboratories are suspended. The provisions of Tennessee Code Annotated, Section 68-29-106, are hereby suspended to the extent necessary to suspend the requirement that the Department of Health conduct inspections for medical laboratory applicants for licensure if the applicant laboratory is physically located in the same location where another licensed medical laboratory was located within the thirty (30) days preceding the submission of the new application. In instances where the Department of Health elects to not inspect a medical laboratory applying for licensure, such provisions requiring a medical laboratory applying for licensure to be inspected are hereby suspended.
- 7.13 Live human examinations are suspended for dentistry applicants. The requirements under Tennessee Code Annotated, Title 63, Chapter 5, and Tenn. Comp R. & Regs. 0460-02-.05 that persons applying for licensure as a dentist complete a live human patient examination component is hereby suspended to permit the Board of Dentistry to grant licensure to persons graduating in 2020 or 2021 from a dental school accredited by the Commission on Dental Accreditation (CODA), if such persons have completed the other licensure requirements, met all of the requirements for competency promulgated by the CODA, and been certified by the dean of their CODA-accredited dental school as qualified, competent, and fit to practice dentistry.

- 7.16 Nursing graduates may practice under supervision without examination. The provisions of Tennessee Code Annotated, Title 63, Chapters 6 and 7, and related rules and policies are hereby suspended to the extent necessary to give the Commissioner of Health the authority and discretion to allow a person who has graduated on or after December 1, 2019, from an approved registered or practical nursing education program, and who has applied and fulfilled all other requirements for licensure as a nurse but has yet to take the National Council Licensure Exam (NCLEX), to practice nursing under the supervision of a licensed registered nurse.
8. Pharmacists can process prescriptions remotely. The relevant portions of Tennessee Code Annotated, Title 63, Chapter 10, and Tenn. Comp. R. & Regs. 1140-02-.01 through Tenn. Comp. R. & Regs. 1140-02-.02 are hereby suspended to the extent necessary to allow pharmacy technicians and pharmacists to complete computer-based processing of prescriptions at alternative locations, including from the residence of the pharmacy technician or pharmacist. Such computer-based processing shall be conducted utilizing adequate security to ensure all aspects of the Health Insurance Privacy and Accountability Act of 1996 are followed. No laws pertaining to licensed pharmacy practice sites, the storage of drugs, recordkeeping, or dispensing processes are waived or limited by this Order.
- 8.1 Each pharmacist can supervise more pharmacy technicians. The provisions of Tenn. Comp. R. & Regs. 1140-02-.02(7) are hereby suspended so that there is no restriction on the ratio of pharmacy technicians to pharmacists while this Order is in effect. All statutes and rules regarding the supervision of a pharmacy technician by a licensed pharmacist remain in full force and effect, including, but not limited to, the requirement that a licensed pharmacist supervise, direct, and verify the accuracy of all pharmacy technician functions pursuant to Tenn. Comp. R. & Regs. 1140-02-.02(9).
9. Degree holders in science fields can work as laboratory personnel under supervision. The relevant portions of Tennessee Code Annotated, Title 68, Chapter 29, and related rules are hereby suspended to the extent necessary to give the Commissioner of Health the discretion to allow individuals required to be licensed under Title 68, Chapter 29, as medical laboratory technologists, medical laboratory technicians, or special analysts to work without a license while employed by a licensed medical laboratory and working under the supervision of a medical laboratory director; provided, that, such an individual has obtained a bachelor's degree in a biology or chemistry science field. The Commissioner of Health shall provide the requisite form for practicing under this Paragraph on the Department of Health's Health Professional Boards webpage.
- 9.1 Medical laboratory directors can monitor facilities remotely. The provisions of Tenn. Comp. R. & Regs. 1200-06-01-.20(5)(c) are hereby suspended to the extent necessary to suspend the requirement that a medical laboratory director make certain periodic in-person, onsite visits to the facilities the director oversees, so long

as the director utilizes other technological means of maintaining and exercising oversight.

- 9.2 Pre-license, graduate or doctoral level mental or behavioral health professionals can provide telehealth services under supervision. The relevant provisions of Tennessee Code Annotated, Titles 63 and 68, and related rules are hereby suspended to the extent necessary to give the Commissioner of Health the authority to allow persons who have completed or are actively enrolled in a program to obtain a master's degree or doctoral degree in a behavioral or mental health field, or in a field of study required for a license allowing the individual to diagnose behavioral or mental health disorders, to treat diagnosed behavioral or mental health conditions without a license and through use of telemedicine services; provided, that the person is, at all times, supervised by a person licensed under Title 63 or Title 68, Chapter 24 with authorization to diagnose a behavioral or mental health condition. The Commissioner of Health shall provide the requisite form for practicing under this Paragraph 9.2 on the Department of Health's Health Professional Boards webpage.
- 9.3 Medical laboratory personnel can work remotely. The provisions of Tenn. Comp. R. & Regs. 1200-06-03-.02(1)(b) are hereby suspended to allow medical laboratory personnel to remotely review electronic data and report laboratory results without having a separate laboratory license for each remote location. Such personnel must be employed by a licensed medical laboratory and working under the supervision of a laboratory director. This suspension does not otherwise alter or amend any licensee's scope of practice or recordkeeping requirements.
- 9.4 Pre-license, graduate or doctoral level audiology and speech language pathology professionals can provide telehealth services under supervision. The relevant provisions of Tennessee Code Annotated, Title 63, and related rules are hereby suspended to the extent necessary to give the Commissioner of Health the authority to allow persons who have completed or are actively enrolled in a program to obtain a master's degree or doctoral degree in the field of audiology or speech language pathology to practice without a license and through use of telemedicine services; provided, that the person is, at all times, supervised by a person licensed under Title 63 in that field. The Commissioner of Health shall provide the requisite form for practicing under this Paragraph 9.4 on the Department of Health's Health Professional Boards webpage.
10. Increased number of hospital beds available for COVID-19 patients. The provisions of Tennessee Code Annotated, Section 68-11-1607, are hereby suspended to the extent necessary to allow hospitals, nursing homes, and home health agencies that would otherwise be subject to certificate of need requirements to temporarily increase their number of licensed hospital beds at any location or temporarily establish hospital, nursing home, home-based, and diagnostic services at any location, if necessary for the treatment of COVID-19 patients, as well as to the

extent necessary to facilitate activity authorized by the provisions of this Order and any subsequent order concerning COVID-19.

10.2 Medical professional staffing flexibility is permitted pursuant to an approved plan to relieve the capacity strain on certain staffing functions. In order to relieve the capacity strain on bedside care and support resulting from staffing shortages (nurses, respiratory therapists, etc.), additional temporary regulatory flexibility measures are necessary to cope with the emergency. To this end, the provisions of Title 63 and Title 68, Chapter 140, are hereby suspended to the extent necessary to authorize professionals licensed under Title 63 or Title 68, Chapter 140, to perform tasks outside of their licensed scope of practice if such tasks are performed in a hospital licensed under Title 68 pursuant to a facility-specific, COVID-19-related plan of delegation that has been submitted by the facility's chief medical officer and approved by the Commissioner of Health or the Commissioner's designee. Such a plan of delegation must include the specific types of licensees covered, the specific tasks outside of their licensed scope of practice that are permitted, and the specific circumstances and directives under which such tasks are permitted. The Commissioner or the Commissioner's designee may approve such plan subject to conditions and may rescind such approval in the Commissioner's or Commissioner's designee's sole discretion. For purposes of regulation and disciplinary action, licensees performing tasks pursuant to this provision remain subject to regulation and disciplinary action as if they were acting within their licensed scope of practice.

10.3 Discretion to utilize National Guard and State Guard members in connection with certain health care and emergency services operations. This Paragraph 10.3 is issued for the limited purpose of authorizing personnel recognized under Tennessee Code Annotated, Sections 58-1-203, 58-1-204, and 58-1-402 (collectively, "Personnel"), to serve in certain health care and emergency services roles to reduce system capacity strain resulting from COVID-19. Namely, Personnel may: (1) perform authorized diagnostic testing for COVID-19 in health care settings, including but not limited to hospitals, emergency departments, and alternate care sites (collectively, "Facilities"); (2) perform authorized nursing and other functions in Facilities; and (3) operate public or privately owned, permitted ambulance service vehicles with a licensed service. Accordingly, the following provisions are hereby suspended to the extent necessary to facilitate this Paragraph 10.3: Tennessee Code Annotated, Titles 63 and Title 68, and related rules, with respect to licensure, continuing education, and other requirements for Personnel or Facilities utilizing Personnel; Title 68, Chapter 140, Part 3, with respect to Personnel and licensed ambulance services utilizing Personnel; and any other state or local law, order, rule, or regulation that would limit the application of this Paragraph 10.3 is hereby suspended to the extent necessary to facilitate this Paragraph 10.3. This Paragraph 10.3 is subject to the following conditions:

- a. No Personnel shall operate under this Paragraph 10.3 unless designated by the Adjutant General upon request or order of the Governor;

- b. Personnel operating pursuant to this Paragraph 10.3 shall have the appropriate training or skills in the area(s) pertaining to their designations;
- c. The Adjutant General and Commissioner of Health, or their designees, shall determine the Facilities to which Personnel are assigned, based on need and other reasonable factors, in their sole discretion;
- d. Any Facility to which Personnel are assigned must submit, in writing to the Commissioner of Health, the responsibilities and tasks that Personnel will be undertaking while operating pursuant to this Paragraph 10.3;
- e. A list of Personnel designated to operate under this Paragraph 10.3 and the Facility or setting in which such Personnel will be operating shall be provided to the Commissioner of Health by the Adjutant General, and this list shall be updated from time to time as necessary;
- f. Any authority, duties, or scope of practice suspensions extended to Personnel pursuant to this Paragraph 10.3 shall terminate and be of no further force and effect upon the expiration or termination of Paragraph 10.3 or other order of the Governor to that effect; and
- g. This Paragraph 10.3 shall not affect the requirements and provisions of the suspended statutory and rule provisions with respect to any other person or facility.

10.4 Regulatory flexibility for ambulance transport services. In order to relieve the capacity strain on emergency medical services, temporary regulatory flexibility measures are necessary for nonemergency ambulance transport services. To this end, the provisions of Tennessee Code Annotated, Title 68, Chapter 140, and Tenn. Comp. R. & Reg. 1200-12-01-.14(3)(c)(2)(iii) & (iv) are hereby suspended to the extent necessary to authorize that Level 3 transports may be staffed with one AEMT and Level 4 transports may be staffed with one EMT, provided that there is an ambulance operator in addition to the AEMT or EMT who satisfies the ambulance driver requirements of Tenn. Comp. R. & Reg. 1200-12-01-.10. All other statutes and rules regarding patient transport services remain in full force and effect.

10.5 Delegation of nursing tasks to medical assistants under the supervision of a registered nurse is permitted to relieve the capacity strain on vaccination and other staffing functions. In order to ensure prompt administration of a COVID-19 vaccination and relieve the capacity strain on bedside care and support resulting from staffing shortages due to COVID-19, additional temporary regulatory flexibility measures are necessary to cope with the emergency. The provisions of Title 63 and related rules are hereby suspended to the extent necessary to authorize a registered nurse, licensed in Tennessee or working in Tennessee on a multi-state privilege to practice, to delegate to medical assistants certified or registered by the

American Association of Medical Assistants, American Medical Technologists, National Association for Health Professionals, National Center for Competency Testing, or National Healthcareer Association tasks that would normally be within the practical nurse scope of practice, including, but not limited to, administration of COVID-19 vaccinations, under the supervision of the registered nurse. Tasks delegated to certified medical assistants and performed under the supervision of the delegating registered nurse are required to have been ordered and authorized by a Tennessee licensed practitioner with prescriptive authority.

- 10.6 Behavioral health inpatient psychiatric, residential, and crisis care staffing flexibility is permitted pursuant to an approved plan to relieve the capacity strain on certain staffing functions. In order to relieve the capacity strain on bedside care and support resulting from staffing shortages (physician assistants, nurse practitioners, registered nurses, licensed practical nurses, etc.), additional temporary regulatory flexibility measures are necessary to cope with the emergency. To this end, the provisions of Title 33, Title 63, and Title 68, Chapter 140, and related rules are hereby suspended to the extent necessary to authorize professionals licensed under Title 63 or Title 68, Chapter 140, to perform tasks outside of their licensed scope of practice or restricted under Title 33 if such tasks are performed in an inpatient psychiatric facility, in a behavioral health residential facility, or by a behavioral health crisis services provider licensed under Title 33 pursuant to a facility or provider-specific, COVID-19-related plan of delegation that has been submitted by the facility's or provider's chief medical or chief executive officer and jointly approved by the Commissioner of Mental Health and Substance Abuse Services or the Commissioner's designee and the Commissioner of Health or the Commissioner's designee. Such approval by either Commissioner or Commissioner's designee may be subject to conditions or may be subsequently rescinded in that person's sole discretion. Such a plan of delegation must include the specific types of licensees covered, the specific tasks outside of their licensed scope of practice or restricted under Title 33 that are permitted, and the specific circumstances and directives under which such tasks are permitted. For purposes of regulation and disciplinary action, licensees performing tasks pursuant to this provision remain subject to regulation and disciplinary action as if they were acting within their licensed scope of practice.
- 10.7 Health care student staffing flexibility is permitted in inpatient acute care and rehabilitation and emergency settings pursuant to an approved plan to relieve the capacity strain on certain staffing functions. In order to relieve the capacity strain on bedside care resulting from staffing shortages related to inpatient acute care, inpatient behavioral health, and emergency care, additional temporary regulatory flexibility measures are necessary to cope with the emergency. To this end, the provisions of Title 63 and Title 68, Chapter 140, and related rules are hereby suspended to the extent necessary to authorize students actively enrolled in a graduate school program or an undergraduate respiratory care program, the educational standards of which meet the training requirements for a license under Title 63 or Title 68, Chapter 140, to perform supervised tasks within the licensed

scope of practice of such a license, if such tasks are performed in an inpatient acute care or inpatient rehabilitation setting or emergency department pursuant to a facility-specific, COVID-19-related plan of delegation that has been submitted by the facility's chief medical officer and approved by the Commissioner of Health or the Commissioner's designee. Such a plan of delegation must include the specific types of programs in which a student must be enrolled to perform tasks in accordance with this Paragraph 10.7, the specific tasks within the relevant scope of practice that the student is permitted to perform, and the specific circumstances and directives under which such tasks are permitted. The Commissioner or the Commissioner's designee may approve such plan subject to conditions and may rescind such approval in the Commissioner's or Commissioner's designee's sole discretion. Students performing tasks pursuant to this Paragraph 10.7 may be subject to disciplinary action upon applying for a license for actions inconsistent with the practice act for the licensed scope of practice in which they are operating.

- 10.8 Health care student staffing flexibility is permitted in inpatient psychiatric and behavioral health settings pursuant to an approved plan to relieve the capacity strain on certain staffing functions. In order to relieve the capacity strain on bedside care resulting from staffing shortages related to inpatient acute care, inpatient behavioral health, and emergency care, additional temporary regulatory flexibility measures are necessary to cope with the emergency. To this end, the provisions of Title 33, Title 63, and Title 68, Chapter 140, and related rules are hereby suspended to the extent necessary to authorize students actively enrolled in a graduate school program or an undergraduate respiratory care program, the educational standards of which meet the training requirements for a license under Title 63 or Title 68, Chapter 140, to perform supervised tasks within the licensed scope of practice of such a license or restricted under Title 33, if such tasks are performed in an inpatient psychiatric facility, in a behavioral health residential facility, or by a behavioral health crisis services provider licensed under Title 33 pursuant to a facility or provider-specific, COVID-19-related plan of delegation that has been submitted by the facility's or provider's chief medical or chief executive officer and jointly approved by the Commissioner of Mental Health and Substance Abuse Services or the Commissioner's designee and the Commissioner of Health or the Commissioner's designee. Such a plan of delegation must include the specific types of programs in which a student must be enrolled to perform tasks in accordance with this Paragraph 10.8, the specific tasks within the relevant scope of practice or restricted under Title 33 that the student is permitted to perform, and the specific circumstances and directives under which such tasks are permitted. Such approval by either Commissioner or Commissioner's designee may be subject to conditions or may be subsequently rescinded in that person's sole discretion. Students performing tasks pursuant to this Paragraph 10.8 may be subject to disciplinary action upon applying for a license for actions inconsistent with the practice act for the licensed scope of practice in which they are operating.
11. Testing for COVID-19 can occur at more medical laboratory facilities. The provisions of Tenn. Comp. R. & Regs. 1200-06-03-.16 are suspended to allow

testing necessary for the diagnosis, treatment, and containment of COVID-19 to occur at alternate testing sites without prior approval by the Medical Laboratory Board; provided, that laboratories shall notify the Medical Laboratory Board of any such alternate testing sites.

12. Temporary quarantine and isolation facilities may be constructed. The provisions of Tennessee Code Annotated, Section 68-11-202(c)(1)-(8), are hereby suspended to allow for the construction of temporary structures, the plans for which would otherwise be subject to review for new construction, additions, or substantial alterations, as directed by the Commissioner of Health and the Director of TEMA in response to COVID-19; provided, that there shall be inspections of such structures to ensure safety, as necessary.
- 16.1 Unemployment benefits for persons affected by COVID-19. The provisions of Tennessee Code Annotated, Title 50, Chapter 7, and related rules are hereby suspended to the extent necessary to allow the Commissioner of Labor and Workforce Development to comply with, and maximize the benefits to the State from, federal legislation related to emergency unemployment benefits, including any extension of, or modification to, the Coronavirus Aid, Relief, and Economic Security Act enacted on March 27, 2020, as Public Law No. 116-136.
21. Board of Parole may modify procedures to protect public health. The provisions of Tennessee Code Annotated, Section 40-28-118(a) and (b), Section 40-28-121(b) and (d), Section 40-28-122(a), (c), and (f), and Section 40-35-503(d), (e), (f), and (h), requiring the Tennessee Board of Parole to take certain actions and conduct certain proceedings, the provisions of Tennessee Code Annotated, Section 40-28-502(a)(1), requiring that hearings be open to the public, the notification requirements of Tennessee Code Annotated, Section 40-28-505(b), (c), (e), and (g), and any related provisions of Tenn. Comp. R. & Regs. 1100-01-01-.01 through Tenn. Comp. R. & Regs. 1100-01-01-.16 and Board of Parole policies adopted pursuant to Tennessee Code Annotated, Section 40-28-104, are hereby suspended. However, the Board of Parole is directed to use all available processes, alternatives, and technology to maintain continuity of services and hearings to the greatest extent practicable while maintaining the health and safety of all persons involved.
- 21.1 Suspends temporary application of safety valve provisions resulting from the temporary decrease in TDOC prisoners. The provisions of Tennessee Code Annotated, Sections 41-1-505(a) and 41-1-508(c), requiring the automatic reversion of release eligibility dates of certain felony offenders to the dates in existence prior to their reductions pursuant to Title 41, Chapter 1, Part 5 upon attainment of ninety percent (90%) of the relevant designated capacity of the state correctional facilities are hereby suspended.
- 23.6 Commercial diver licenses with medical cards are extended. Consistent with the February 16, 2021, Federal Motors Carrier Safety Administration waivers, the provisions of Tennessee Code Annotated, Section 55-50-413, are hereby

suspended, as follows, to the extent necessary to delay the cancellation of a Class A, B, or C driver license with a medical card issued for more than ninety (90) days: Class A, B, and C driver license holders whose medical cards were set to expire from December 1, 2020, through March 29, 2021, will have until March 29, 2021, to submit a new medical card to the Department of Safety and Homeland Security to avoid cancellation, regardless of other termination dates that may be specified in the federal waiver. Renewal requirements shall return to their original schedule in subsequent years. Drivers who, since their last medical certificate was issued, have been diagnosed with a medical condition that would disqualify the driver from operating in interstate commerce, or who, since their last medical certificate was issued, have developed a condition that requires an exemption or Skill Performance Evaluation from FMCSA are not covered under the suspension in this paragraph.

27. Educational and training deadlines administered by the Department of Commerce and Insurance may be extended. The provisions governing the initial issuance and renewal of licenses, permits, and certifications issued by the Department of Commerce and Insurance and the boards, commissions, and agencies administratively attached to the Department are suspended to the extent necessary to give the Commissioner of Commerce and Insurance and the boards, commissions, and agencies discretion to reasonably extend the deadline for obtaining the required testing, education, continuing education, or in-service credits as necessary to respond to the effects of COVID-19.
28. Deadlines for building code, building plan, electrical, and residential inspections may be extended. The provisions governing building plans review or building code requirements or electrical or residential inspections under the purview of the Department of Commerce and Insurance are suspended to the extent necessary to give the Commissioner of Commerce and Insurance discretion to reasonably extend the deadline for compliance with such provisions as necessary to respond to the effects of COVID-19.
33. Inspections of mental health and substance abuse facilities and services are suspended. The provisions of Tennessee Code Annotated, Section 33-2-413(a), are hereby suspended to the extent necessary to give the Commissioner of Mental Health and Substance Abuse Services the authority to suspend the required unannounced life safety and environmental inspections of licensed services or facilities, absent the death of a service recipient at the service or facility with an indication of possible abuse or neglect by the service or facility or its employees or a request for placement assistance from law enforcement or state or federal agencies regarding the service or facility.
- 33.1 Telephone assessments for involuntary commitment cases are permitted. The provisions of Tennessee Code Annotated, Section 33-4-108, are hereby suspended to the extent necessary to allow the issuance of a certificate of need under Tennessee Code Annotated, Section 33-6-404, for the emergency involuntary commitment of a person with a mental illness or serious emotional disturbance based upon a

telephone assessment of such person by a mandatory pre-screening agent designated pursuant to Tennessee Code Annotated, Sections 33-6-104 and 33-6-427, if the following conditions are met:

- a. The mandatory pre-screening agent is not reasonably able to conduct an evaluation in-person or via readily available telehealth services; and
  - b. The mandatory pre-screening agent determines in the agent's professional judgment that conducting the assessment via telephone with the person is clinically appropriate.
34. TennCare policies adjusted to prevent coverage disruptions. The Division of TennCare is hereby authorized to create policies or modify existing policies as is necessary to ensure that members of the TennCare and CoverKids programs continue to receive medically necessary services without disruption during this state of emergency.
- 34.1 Designation and Payment for Certain Nursing Facilities as "COVID-19 Skilled Nursing Facilities/Units." The provisions of Tennessee Code Annotated, Titles 4, 68, and 71 and related rules, regulations, and policies are hereby suspended to the extent necessary to provide the Department of Health and the Division of TennCare the necessary authority and discretion to select, designate, and reimburse certain nursing facilities, or units within certain nursing facilities, as "COVID-19 Skilled Nursing Facilities/Units."
- 34.2 Medicaid Payments to "COVID-19 Skilled Nursing Facilities/Units." The provisions and requirements of Tennessee Code Annotated, Section 71-5-105, are hereby suspended to the extent necessary to permit the Division of TennCare to implement additional acuity-based payments for Medicaid members in nursing facilities designated as "COVID-19 Skilled Nursing Facilities/Units".
38. Telemedicine access is expanded. Health insurance carriers are urged to provide coverage for the delivery of clinically appropriate, medically necessary covered services via telemedicine to all providers, irrespective of network status or originating site. Providers are urged to follow the new guidance from the federal Centers for Medicare and Medicaid Services regarding equipment and everyday communications technologies that may be used for the provision of telemedicine services. Carriers are urged not to impose prior authorization requirements on medically necessary treatment related to COVID-19 delivered by in-network providers via telemedicine. Health care professionals licensed in another state who are authorized pursuant to this Order to temporarily practice in this State are permitted to engage in telemedicine services with patients in Tennessee to the extent the scope of practice of the applicable professional license in this State would authorize the professional to diagnose and treat humans. Tennessee Code Annotated, Section 63-1-155(c)(3), is hereby suspended to allow telemedicine

services by pain management clinics, as defined in Tennessee Code Annotated, Section 63-1-301(7), and in the case of chronic nonmalignant pain treatment.

- 38.1 All licensed health care providers can practice telemedicine. The provisions of Tennessee Code Annotated, Section 63-1-155(a)(1), are hereby suspended to the extent necessary to allow telehealth or telemedicine services to be provided by any provider licensed under Title 63, regardless of the provider's authority to diagnose. This suspension does not otherwise alter or amend any licensee's scope of practice or record keeping requirements.
- 38.2 Licensed alcohol and drug abuse counselors can practice telemedicine. The provisions of Tennessee Code Annotated, Section 63-1-155(a)(1), and any other state or local law, order, rule, or regulation that would limit the application of this Paragraph 38.2 are hereby suspended, retroactively to March 26, 2020, when Paragraph 38.1 of Executive Order No. 36 suspended provisions of law to permit telemedicine by other licensed health care providers, to the extent necessary to allow telehealth or telemedicine services to be provided by an alcohol and drug abuse counselor licensed under Title 68. This suspension does not otherwise alter or amend an alcohol and drug abuse counselor's scope of practice or record keeping requirements.
- 38.3 Hospital-level care in home program and telemedicine access expansion is encouraged. In order to relieve the capacity strain on inpatient care due to COVID-19, health insurance carriers are urged to provide equivalent inpatient reimbursement to all providers for the delivery of clinically appropriate, medically necessary covered services via programs in which patients receive hospital-level care in home, irrespective of network status or originating site. Providers are urged to follow the new guidance from the federal Centers for Medicare and Medicaid Services regarding equipment and everyday communications technologies that may be used for the provision of telemedicine services. Carriers are urged to not impose additional prior authorization requirements on medically necessary treatment related to COVID-19 delivered via programs in which patients receive hospital-level care in home.
39. Collaborative pharmacy practice agreement for vaccinations. The chief medical officer of the Department of Health is authorized to implement a statewide collaborative pharmacy practice agreement specific to the administration and dispensing of the COVID-19 vaccine with any pharmacist licensed in and practicing in Tennessee. The provisions of Title 63 and related rules are hereby suspended to the extent necessary to authorize a pharmacist licensed under Title 63 to enter into the collaborative practice agreement with the chief medical officer of the Department of Health. A pharmacist entering into the statewide collaborative pharmacy practice agreement must attest and maintain proof that the pharmacist satisfies all of the requirements to qualify as a "covered person" under 42 U.S.C. § 247d-6d(i)(8)(B) pursuant to the HHS Guidance dated September 3, 2020. For each intern or technician for whom the pharmacist is the supervising qualified

pharmacist, the pharmacist must attest and maintain proof that the intern or technician satisfies all of the requirements to qualify as a “qualified person” under 42 U.S.C. § 247d-6d(i)(8)(B), pursuant to HHS Guidance dated October 20, 2020. For purposes of regulation and disciplinary action, licensees performing tasks pursuant to this provision remain subject to regulation and disciplinary action as if they were acting within their licensed scope of practice. Students performing tasks pursuant to this paragraph may be subject to disciplinary action upon applying for a license for actions inconsistent with the licensed scope of practice for which they are operating.

**B. Restated provisions that originated in Executive Order No. 38 (as amended in other orders or herein):**

2. Sports and athletics. Local education agencies and schools shall, notwithstanding any orders or provisions to the contrary, have the authority to permit, but are not required to permit, school-sponsored sporting events and activities, provided that all such activities, including practices and games or competition, must be conducted in a manner consistent with COVID-19-related guidance and rules adopted by the Tennessee Secondary Schools Athletic Association. Non-school-sponsored athletics, including practices and games or competition, must be conducted in a manner consistent with guidance from the Tennessee Economic Recovery Group (i.e., Tennessee Pledge). Collegiate and professional sporting events and activities must be conducted pursuant to the rules or guidelines of their respective governing bodies.
  
12. Take-out alcohol sales by restaurants and limited-service restaurants to continue in order to encourage carryout or delivery orders. The provisions of Tennessee Code Annotated, Title 57, and related rules and other state or local laws, orders, rules, or regulations are temporarily suspended to the extent necessary to allow restaurants and limited service restaurants, as defined in Tennessee Code Annotated, Section 57-4-102, and wine-only restaurants, as permitted by Tennessee Code Annotated, Section 57-4-101(c), to sell for take-out or delivery alcoholic beverages or beer, so long as the following conditions are met:
  - a. Any sale of an alcoholic beverage or beer is for consumption off of the premises of the restaurant, limited service restaurant, or wine-only restaurant (collectively referred to hereafter as “restaurant”) and is accompanied by the sale of food in the same order;
  
  - b. An alcoholic beverage or beer sold under this Paragraph 12 must be packaged in a container or bottle with a secure lid or cap and in a manner designed to prevent consumption without removal of the lid or cap, and customers shall not remove such lids or caps while operating a motor vehicle;

- c. Single servings of alcoholic beverages or beer and multi-serving bottles or containers of beer or wine normally sold by the restaurant may be sold under this Paragraph 12, but not bottles of spirits or liquor;
- d. A restaurant selling alcoholic beverages or beer under this Paragraph 12 shall prominently post a warning in a manner reasonably calculated to provide notice to customers of open container laws, which must include the following language from Tennessee Code Annotated, Section 55-10-416: “No driver shall consume any alcoholic beverage or beer or possess an open container of alcoholic beverage or beer while operating a motor vehicle in this state.”;
- e. An employee or contractor of a restaurant providing or delivering alcoholic beverages or beer to a customer under this Paragraph 12 shall not provide or deliver such beverages to any person under twenty-one (21) years of age and may not provide or deliver such beverages to a person who is visibly intoxicated. Any such employee providing or delivering alcoholic beverages or beer must visually inspect a valid government-issued document deemed acceptable to the restaurant that includes the photograph and birth date of the adult consumer attempting to make an alcoholic beverage purchase and confirms that the person is at least twenty-one (21) years of age;
- f. A person delivering alcoholic beverages or beer under this Paragraph 12 must be at least twenty-one (21) years of age and must have a valid driver license; and
- g. An alcoholic beverage or beer sold under this Paragraph 12 must be sold during current operating hours.

12.1 Waiver of application fee to expand premises. The provisions of Tennessee Code Annotated, Title 57, and related rules and other state or local laws, orders, rules, or regulations are temporarily suspended to the extent necessary to waive the \$300.00 application fee for restaurants, limited service restaurants, and all other establishments licensed under Title 57, Chapter 4, that apply to the Alcoholic Beverage Commission to expand the boundary of their premises covered under such license to sell alcoholic beverages for on-premises consumption in response to COVID-19.

13. Local orders.

- a. No local orders permitted regarding dental or medical procedures. In order to ensure a comprehensive approach to the measures needed to conserve personal protective equipment, which is an issue that is statewide in scale, no local official or local governmental entity shall issue an order or measure

regarding the provision of medical, dental, or oral procedures because of COVID-19 absent authority delegated by the Governor.

- b. Local orders in 89 counties without a locally run county health department (all counties except for Davidson, Hamilton, Knox, Madison, Shelby, and Sullivan). The provisions of this Order shall exclusively govern on the subjects they concern in the 89 counties that do not have a locally run county health department, and this Order shall supersede and preempt any emergency order, health order, or other order issued by a local official or local governmental entity that contravenes or would limit the application of the provisions of this Order.
- c. Local orders in six counties with a locally run county health department (Davidson, Hamilton, Knox, Madison, Shelby, and Sullivan). The six locally run county health departments in Davidson, Hamilton, Knox, Madison, Shelby, and Sullivan counties shall have authority to issue additional orders or measures related to the containment or management of the spread of COVID-19, which may permit to a greater degree, or restrict to a greater degree, the opening, closure, or operation of businesses, organizations, or venues in those counties or the gathering of persons; provided that no local official or local governmental entity shall issue an order or measure regarding places of worship or an order or measure that contravenes Paragraphs 6, 9, or 10 of Executive Order No. 38, as restated herein. This Order shall govern on all subjects it concerns, except to the extent that the locally run county health department has issued differing local orders or measures regarding the opening, closure, or operation of businesses, organizations, or venues or the gathering of persons as provided for in this Paragraph 13.
- d. Local orders of a proprietary nature. Nothing in this Order shall affect or limit local orders that do not contravene or limit the application of the provisions of this Order, such as orders or measures in which a local governmental entity acts in a proprietary capacity—for example, with respect to the opening or closure of governmental buildings, employee measures, or government operations.

C. Restated provisions that originated in Executive Order No. 54 (as amended in other orders or herein):

- 2. Specific delegation of authority to issue orders concerning face coverings. Notwithstanding anything to the contrary in Paragraph 13.b. of Executive Order No. 38, as restated herein, county mayors in the 89 counties that do not have a locally run county health department shall have the authority to issue orders or measures requiring or recommending the wearing of face coverings within their jurisdictions, consistent with Paragraph 3 of Executive Order No. 54, as restated herein.

3. Contents of local orders. Orders or measures issued by county mayors pursuant to this Order should be consistent with CDC guidance and may have such exemptions as deemed advisable, provided that, at a minimum, there shall be no requirement that a face covering be worn:
  - i. Within one's residence or automobile, unless transporting others for hire;
  - ii. By a child twelve (12) years of age or younger;
  - iii. By someone who has trouble breathing due to an underlying health condition or another bona fide medical or health-related reason for not wearing a face covering;
  - iv. By someone who is incapacitated or otherwise unable to remove the cloth face covering without assistance;
  - v. While eating or drinking;
  - vi. While outdoors, unless the person cannot substantially maintain appropriate social distancing from others outside of the person's household;
  - vii. While working under conditions where appropriate social distancing from others outside of the person's household is substantially maintained;
  - viii. In situations in which wearing a face covering poses a safety or security risk;
  - ix. While in a house of worship unless required by that house of worship, but wearing a face covering in such locations is strongly encouraged; or
  - x. While in a voting site for the purpose of voting or administering an election, but wearing a face covering in such locations is strongly encouraged.
  
5. Nothing preempts or supersedes any authority of bodies in six counties with a locally run county health department. Nothing herein or in Paragraphs 5 or 13 of Executive Order No. 38, as restated herein, preempts or supersedes any existing authority, as provided by executive order, statute, charter, or otherwise, of a locally run county health department, board of health, official, or local legislative body, located in a county with a locally run county health department, to issue or enact orders, ordinances, rules, or law regarding face coverings to mitigate the spread of COVID-19.
  
6. Effect of Order. A local order promulgated under the authority delegated by this Order constitutes an order, rule, or regulation promulgated pursuant to Tennessee

Code Annotated, Title 58, Chapter 2, Part 1, for purposes of Tennessee Code Annotated, Section 58-2-120.

**D. General Provisions:**

1. Suspension of laws that would limit application of this Order. Any law, order, rule, or regulation that would otherwise limit the enforceability of this Order is hereby suspended, pursuant to Tennessee Code Annotated, Section 58-2-107.
2. Severability. If any provision of this Order or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this Order which can be given effect without the invalid provision or application, and to that end the provisions of this Order are declared to be severable.
3. Term and effective date. This Order takes effect at 11:59 p.m., Central Time, on February 27, 2021, and shall remain in effect until 11:59 p.m., Central Time, on April 28, 2021.

**IN WITNESS WHEREOF**, I have subscribed my signature and caused the Great Seal of the State of Tennessee to be affixed this 26th day of February, 2020.

  
GOVERNOR

ATTEST:

  
SECRETARY OF STATE





## COVID-19

# Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes

Nursing Homes & Long-Term Care Facilities

Updated Mar. 29, 2021 [Print](#)

This guidance summarizes the core infection prevention and control practices for nursing homes during the SARS-CoV-2 pandemic. Some of these recommendations can be modified in response to COVID-19 vaccination. Those modifications, which will be regularly updated, are posted in CDC's [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#).

## Summary of Recent Changes

Updates as of March 29, 2021



- Two prior guidance documents, "Responding to COVID-19 in Nursing Homes" and "Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes" were merged with this guidance.
- The criteria for health department notification was updated to be consistent with Council of State and Territorial Epidemiologist (CSTE) guidance for reporting.
- Information on the importance of vaccinating residents and healthcare personnel (HCP) was added along with links to vaccination resources.
- Visitation and physical distancing measures were updated.
- Added proper use and handling of personal protective equipment (PPE).
- Added universal PPE use to align with the [interim infection prevention and control guidance for HCP](#).
- Added considerations for situations when it might be appropriate to keep the room door open for a resident with suspected or confirmed SARS-CoV-2 infection.
- A description was included about when it may be appropriate for a resident with a suspected SARS-CoV-2 infection to "shelter-in-place."
- Added management of residents who had close contact with someone with SARS-CoV-2 infection which includes a description of quarantine recommendations including resident placement, recommended PPE, and duration of quarantine.
- Added addressing circumstances when quarantine is recommended for residents who leave the facility.
- Added responding to a newly identified SARS-CoV-2-infected HCP or resident.
- Added addressing quarantine and work exclusion considerations for asymptomatic residents and HCP who are within 90 days of resolved infection.

## Key Points

- Older adults living in congregate settings are at high risk of being affected by respiratory and other pathogens, such as SARS-CoV-2.
- A strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP).
- Even as nursing homes resume normal practices and begin relaxing restrictions, nursing homes must sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.
- These recommendations supplement CDC's [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#) and are specific for nursing homes, including skilled nursing facilities, but may also apply to other long-term care and residential settings.

This guidance summarizes the core infection prevention and control practices for nursing homes during the SARS-CoV-2 pandemic. Some of these recommendations can be modified in response to COVID-19 vaccination. Those modifications, which will be regularly updated, are posted in CDC's [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#).

## Introduction

Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like SARS-CoV-2 and other pathogens, including multidrug-resistant organisms (e.g., carbapenemase-producing organisms, *Candida auris*). As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP). Even as nursing homes resume more normal practices and begin relaxing restrictions, nursing homes must sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.

This guidance has been updated and organized according to IPC practices that should remain in place whether or not nursing homes are experiencing outbreaks of SARS-CoV-2. Additional guidance is included to assist nursing homes and public health authorities with resident placement and cohorting decisions when responding to SARS-CoV-2 infections and exposures.

These recommendations supplement CDC's [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#) and are specific for nursing homes, including skilled nursing facilities, but may also be applicable to other long-term care and residential settings.

Unless noted in the [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#), this guidance applies regardless of vaccination status and level of vaccination coverage in the facility.

This guidance summarizes the core infection prevention and control practices for nursing homes during the SARS-CoV-2 pandemic. Some of these recommendations can be modified in response to COVID-19 vaccination. Those modifications, which will be regularly updated, are posted in CDC's [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#).

## Infection Prevention and Control Program

Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the IPC Program

- This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on the

resident population and facility service needs identified in the [IPC risk assessment](#).

- CDC has created an [online training course](#) that can orient individuals to this role in nursing homes.

#### Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices

- Hand Hygiene Supplies:
  - Put FDA-approved alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).
  - Unless hands are visibly soiled, [performing hand hygiene](#) using an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations (e.g., before and after touching a resident) due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands.
  - Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Personal Protective Equipment (PPE):
  - Employers should select appropriate PPE and provide it to HCP in accordance with Occupational Safety and Health Administration (OSHA) [PPE standards \(29 CFR 1910 Subpart I\)](#)
  - Facilities should have supplies of [facemasks](#), N95 or higher-level respirators, gowns, gloves, and eye protection (i.e., face shield or goggles).
  - Implement a [respiratory protection program](#) that is compliant with the OSHA respiratory protection standard (29 CFR 1910.134) for employees if not already in place. The program should include [medical evaluations](#), training, and fit testing.
  - Perform and maintain an inventory of PPE in the facility.
    - Monitor daily PPE use to identify when supplies will run low; use the [PPE burn rate calculator](#) or other tools.
    - Identify [health department or healthcare coalition](#) contacts for getting assistance during PPE shortages.
    - Use the Supplies and PPE pathway in the [National Healthcare Safety Network \(NHSN\) Long-term Care Facility \(LTCF\) COVID-19 Module](#) to indicate critical PPE shortages (i.e., less than one week supply remaining despite use of [CDC PPE optimization strategies](#)).
  - Make necessary PPE available in areas where resident care is provided.
    - Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback, promoting appropriate use by staff.
  - Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room.
  - Follow [CDC PPE optimization strategies](#), which offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted.
- Environmental Cleaning and Disinfection:
  - Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas.
  - Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
  - Use an EPA-registered disinfectant from [List N: disinfectants for coronavirus \(COVID-19\)](#) on the EPA website to disinfect surfaces that might be contaminated with SARS-CoV-2. Ensure HCP are appropriately trained on its use and follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method, and contact time).

#### Educate Residents, Healthcare Personnel, and Visitors about SARS-CoV-2, Current Precautions Being Taken in the Facility, and Actions They Should Take to Protect Themselves

- Provide culturally and linguistically tailored information about [SARS-CoV-2 infection](#), including the signs and symptoms that could signal infection.
- Provide information about strategies for [managing stress and anxiety](#).

- Regularly review CDC's [Interim Infection Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic](#) for current information and ensure staff and residents are updated when this guidance changes.
- Educate and train HCP, including facility-based and consultant personnel (e.g., rehabilitation therapy, wound care, podiatry, barber), ombudsman, and volunteers who provide care or services in the facility. Including consultants is important since they commonly provide care in multiple facilities where they can be exposed to and serve as a source of SARS-CoV-2.
  - Educate HCP about any new policies or procedures.
  - Reinforce sick leave policies and remind HCP not to report to work when ill.
  - Reinforce adherence to standard IPC measures including [hand hygiene](#) and [selection and correct use of PPE](#). Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities.
    - CDC has created [training resources](#) for front-line staff that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
- Educate residents and families through educational sessions and written materials on topics including information about SARS-CoV-2, actions the facility is taking to protect them and their loved ones, any visitor restrictions that are in place, and actions they should take to protect themselves in the facility, emphasizing the importance of source control, [physical distancing](#) and [hand hygiene](#).
- Have a plan and mechanism to regularly communicate with residents, families and HCP, [including if cases of SARS-CoV-2 infection are identified among residents or HCP](#).

Find the contact information for the [healthcare-associated infections program in your state health department](#) as well as [your local health department](#)

Notify HCP, residents, and families about outbreaks, and report SARS-CoV-2 infection, facility staffing, testing, and supply information to public health

- Notify the health department promptly [■](#) [🔗](#) about any of the following:
  - $\geq 1$  residents or HCP with suspected or confirmed SARS-CoV-2 infection,
  - Resident with severe respiratory infection resulting in hospitalization or death, or  $\geq 3$  residents or HCP with acute illness compatible with COVID-19 with onset within a 72 hour period
- Notify HCP, residents, and families [promptly about identification of SARS-CoV-2 in the facility](#) [■](#) [🔗](#) and maintain ongoing, frequent communication with residents, families, and HCP with updates on the situation and facility actions.
- Report SARS-CoV-2 infections, facility staffing and supply information, and [point of care testing data](#) to the [National Healthcare Safety Network \(NHSN\) Long-term Care Facility \(LTCF\) COVID-19 Module](#) weekly. CDC's NHSN provides long-term care facilities with a secure reporting platform to track infections and prevention process measures in a systematic way.
  - Weekly data submission to NHSN will meet the Centers for Medicare and Medicaid Services (CMS) [COVID-19 reporting requirements](#) [■](#) [🔗](#)

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## Vaccinations

Vaccinate Residents and HCP against SARS-CoV-2

- Receiving a [COVID-19 vaccination](#) is an important step to prevent getting sick with COVID-19 disease. CDC continues to stress the importance of getting vaccinated when it is offered to you.
- The [Long-Term Care Facility Toolkit: Preparing for COVID-19 Vaccination at Your Facility](#) provides resources including information on preparing for vaccination, vaccination safety monitoring and reporting, frequently asked questions, and printable tools.
- Weekly vaccination numbers of nursing home residents and HCP can be reported into the [NHSN LTCF Weekly HCP & Resident COVID-19 Vaccination Reporting module](#).
- Guidance on adjustment to IPC recommendations following vaccination is available in CDC's [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#).

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## Source Control and Distancing Measures

### Implement Source Control Measures

- Source control refers to use of well-fitting [cloth masks](#), [facemasks](#), or [respirators](#) to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. In addition to providing source control, these devices also offer varying levels of protection against exposure to infectious droplets and particles produced by infected people. Fit-tested respirators are most protective for the wearer. Ensuring a proper fit is important to optimize both the source control and protection offered. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19.
- Residents, if tolerated, should wear a well-fitting form of source control upon arrival and throughout their stay in the facility. Residents may remove their source control when in their rooms but should put it back on when around others (e.g., HCP or visitors enter the room) and whenever they leave their room, including when in common areas or when outside of the facility. [More information on options to improve fit is available from CDC](#).
  - Source control should not be placed on anyone who cannot wear a mask safely, such as someone who has a disability or an underlying medical condition that precludes wearing a mask or who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- For additional guidance on recommended source control for HCP, refer to section: [Implement Universal Use of Personal Protective Equipment](#) below.
  - HCP should wear well-fitting source control at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers.
  - To reduce the number of times HCP must touch their face and potential risk for self-contamination, HCP should consider continuing to wear the same respirator or well-fitting facemask throughout their entire work shift when the respirator or facemask is used for source control.
  - HCP should remove their respirator or facemask, perform hand hygiene, and put on their community source control (i.e., [mask](#)), when leaving the facility at the end of their shift.
- Visitors and others who enter the facility (e.g., contractors, people making deliveries), if permitted into the facility, should wear a well-fitting form of source control while in the facility.

### Implement Physical Distancing Measures

- Although most care activities require close physical contact between residents and HCP, when possible, maintaining physical distance between people (at least 6 feet) is an important strategy to prevent SARS-CoV-2 transmission.
- Remind HCP to practice [physical distancing](#) and wear source control when in break rooms or common areas.
- The following activities can be considered for residents who do not have current suspected or confirmed SARS-CoV-2 infection, including those who have fully recovered, and residents who have not had [close contact](#) with a person with SARS-CoV-2 infection:

person with SARS-CoV-2 infection:

- Communal dining and group activities at the facility
  - As activities are occurring in communal spaces and could involve individuals who have not been fully vaccinated, residents should practice physical distancing, wear source control (if tolerated), and perform frequent hand hygiene.
- Social excursions outside the facility
  - Residents and their families should be educated about potential risks of public settings, particularly if they have not been fully vaccinated, and reminded to avoid crowds and poorly ventilated spaces.
  - They should practice physical distancing, wear source control (if tolerated), and perform frequent hand hygiene.
  - Considerations for fully vaccinated residents who are visiting friends or family in a private setting outside the facility are described in the [Interim Public Health Recommendations for Fully Vaccinated People](#)
- They should inform the facility if they have close contact with a person with SARS-CoV-2 infection while outside the facility
- Quarantine considerations for residents who leave the facility are described in [Create a Plan for Residents who leave the Facility](#)

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## Visitation

### Have a Plan for Visitation

- Have a facility plan for managing visitation, including use of restrictions when necessary.
- While facilities are encouraged to facilitate in-person visits whenever possible, the [CMS visitation memo describes](#) [■](#) [☞](#) situations requiring temporary restriction of indoor visitors, except for compassionate care reasons. Please refer to [CMS visitation memo](#) [■](#) [☞](#), [CDC Updated Healthcare IPC Recommendations in Response to COVID-19 Vaccination](#), as well as your state and local health department for additional guidance.
- [Send letters or emails](#) [■](#) to families reminding them not to visit when ill or if they have had close contact with someone with SARS-CoV-2 infection in the prior 14 days.
- Post signs at the entrances to the facility advising visitors to check-in with the front desk to be assessed for symptoms prior to entry.
- [Symptoms of COVID-19](#)
- Fever of 100.0 °F or higher or report feeling feverish
- [Close contact](#) to someone with COVID-19 during the prior 14 days
- Undergoing evaluation for COVID-19 (such as pending [viral test](#)) due to exposure or close contact to a person with COVID-19
- Diagnosis of COVID-19 in the prior 10 days
- Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.
- When visitation is restricted:
  - [Send letters or emails](#) [■](#) to families advising them of the restrictions
  - Facilitate and [encourage alternative methods for visitation](#) [■](#) (e.g., video conferencing) and communication with the resident

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## Personal Protective Equipment

### Ensure Proper Use and Handling of Personal Protective Equipment

- Facilities should have policies and procedures addressing:
  - Which PPE is required in which situations (e.g., residents with suspected or confirmed SARS-CoV-2 infection, residents placed in quarantine)
  - Recommended sequence for safely donning and doffing PPE
- Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses.
- Bundle care activities to minimize the number of HCP entries into a room.
- If PPE shortages are anticipated or exist, implement [CDC PPE optimization strategies](#). CDC Strategies for Optimizing the Supply of PPE during Shortages offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted, and are intended to be implemented sequentially (i.e., implementing contingency strategies prior to implementing crisis strategies).
- Additional information is available:
  - [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#)
  - [Personal Protective Equipment: Questions and Answers](#).
  - [Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages | CDC](#)

### Implement Universal Use of Personal Protective Equipment

- Transmission from asymptomatic or pre-symptomatic residents with SARS-CoV-2 infection can occur in healthcare settings, particularly in geographic areas [with moderate to substantial community transmission](#).
- The fit of the medical device used to cover the wearer's mouth and nose is a critical factor in the level of source control (preventing exposure of others) and level of the wearer's exposure to infectious particles. [Respirators](#) offer the highest level of both source control and protection against inhalation of infectious particles in the air. Facemasks that conform to the wearer's face so that more air moves through the material of the facemask rather than through gaps at the edges are more effective for source control than facemasks with gaps and can also reduce the wearer's exposure to particles in the air. Improving how a facemask fits can increase the facemask's effectiveness for decreasing particles emitted from the wearer and to which the wearer is exposed.
- HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic residents with SARS-CoV-2 infection. If SARS-CoV-2 infection is not suspected in a resident (based on symptom and exposure history):
  - HCP should follow [Standard Precautions](#) (and [Transmission-Based Precautions](#) if required based on the suspected diagnosis; for example, use an N95 respirator or equivalent or higher level respirator if the patient is suspected to have tuberculosis).
  - Additionally, HCP should use PPE as described below:
    - N95 respirators or equivalent or higher-level respirators should be used for
      - All aerosol generating procedures (refer to [Which procedures are considered aerosol generating procedures in healthcare settings FAQ](#))
    - One of the following should be worn by HCP while in the facility and for protection during resident care encounters:
      - A NIOSH-approved N95 respirator OR
      - A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators OR
      - A well-fitting facemask (e.g., selection of a facemask with a nose wire to help the facemask conform to the face; selection of a facemask with ties rather than ear loops; use of a mask fitter; tying the

- facemask's ear loops and tucking in the side pleats; fastening the facemask's ear loops behind the wearer's head; use of a cloth mask over the facemask to help it conform to the wearer's face)
  - Additional information about strategies to improve fit and filtration are available in [Improve the Fit and Increase the Filtration of Your Mask to Reduce the Spread of COVID-19](#).
  - If implementing new strategies or equipment to improve fit, HCP should receive training on how to safely don and doff their facemask and the facility protocol for cleaning and disinfecting any reusable equipment (e.g., fitter). They should also ensure that any new strategies do not impede their vision or ability to breathe.
- Eye protection should be worn during patient care encounters to ensure the eyes are also protected from exposure to respiratory secretions.
- HCP working in areas with minimal to no community transmission should continue to adhere to [Standard and Transmission-Based Precautions](#) based on anticipated exposures and suspected or confirmed diagnoses. This might include use of eye protection, an N95 or equivalent or higher-level respirator, as well as other PPE. In addition, universal use of a well-fitting facemask for source control is recommended for HCP if not otherwise wearing a respirator.

Additional considerations for universal use of PPE in facilities where transmission of SARS-CoV-2 is suspected or identified is described in the section: [Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident](#).

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## Testing

### Create a Plan for Testing Residents and Healthcare Personnel for SARS-CoV-2

- Guidance addressing when to test residents and HCP for SARS-CoV-2 and how to interpret results of antigen tests is available at the following links:
  - [Testing Guidelines for Nursing Homes](#)
  - [Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2](#)
  - [SARS-CoV-2 Antigen Testing in Long Term Care Facilities](#)
- The plan   should align with state and federal requirements for testing residents and HCP for SARS-CoV-2 and address:
  - Triggers for performing testing (e.g., a resident or HCP with symptoms consistent with COVID-19, a resident or HCP with SARS-CoV-2 in the facility, routine testing)
  - Access to tests capable of detecting the virus and an arrangement with laboratories to process tests or capacity to [conduct and process point-of care tests onsite](#)
  - Process for and capacity to perform SARS-CoV-2 testing of all residents and HCP
  - Training for HCP on how to collect and process specimens correctly, including correct use of PPE
  - A procedure for addressing residents or HCP who decline or are unable to be tested (e.g., maintaining Transmission-Based Precautions until [symptom-based criteria](#) are met for a symptomatic resident who refuses testing)
  - A plan to respond to results of the testing prior to initiating testing, for additional information see section: [Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident](#)
- Additional information about testing of residents and HCP is available:
  - [Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings](#), which includes considerations for health departments and nursing homes for facility-wide testing
  - [Interim Final Rule \(IFC\), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care \(LTC\) Facility Testing Requirements and Revised COVID-19 Focused Survey Tool](#)  

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## Evaluating and Managing Personnel and Residents

### Evaluate and Manage Healthcare Personnel

- Implement [sick leave policies](#) that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill.
- Create an inventory of all volunteers and personnel who provide care in the facility. Use that inventory to determine which personnel are non-essential and whose services can be delayed if such restrictions are necessary to prevent or control transmission.
- Establish a process to ensure HCP (including consultant personnel and ancillary staff such as environmental and dietary services) entering the facility are assessed for [symptoms of COVID-19](#) or close contact outside the facility to others with SARS-CoV-2 infection and that they are practicing source control.
  - Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, HCP report absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not had close contact with others with SARS-CoV-2 infection during the prior 14 days.
    - Fever can be either measured temperature  $\geq 100.0^{\circ}\text{F}$  or subjective fever. People might not notice symptoms of fever at the lower temperature threshold that is used for those entering a healthcare setting, so they should be encouraged to actively take their temperature at home or have their temperature taken upon arrival.
- HCP who report symptoms should be excluded from work and should notify occupational health services to arrange for further evaluation. In addition, asymptomatic HCP who report close contact with others with SARS-CoV-2 infection might need to be excluded from work.
  - If HCP develop fever (Temperature  $\geq 100.0^{\circ}\text{F}$ ) or [symptoms consistent with COVID-19](#) while at work they should inform their supervisor and leave the workplace.
- Have a plan for how to respond to HCP with SARS-CoV-2 infection who worked while ill (e.g., identifying exposed residents and co-workers and [initiating an outbreak investigation](#) in the unit or area of the building where they worked).
- Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including providing [resources](#) to assist HCP with anxiety and stress. [Strategies to mitigate staffing shortages](#) are available.
- Information about when non-essential personnel should have limited entry into facilities can be found in the [CMS Re-opening Memo](#)  .
- Information about when HCP with suspected or confirmed SARS-CoV-2 infection may return to work is available in the [Interim Guidance on Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19](#).
- Information about risk assessment and work restrictions for HCP exposed to SARS-CoV-2 is available in the [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to Coronavirus Disease 2019 \(COVID-19\)](#).

### Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with Confirmed SARS-CoV-2 Infection

- Determine the location of the COVID-19 care unit and create a staffing plan.
  - Doing this before residents or HCP with SARS-CoV-2 infection are identified in the facility will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit.
  - Facilities that have already identified cases of SARS-CoV-2 infection among residents but have not developed a COVID-19 care unit should work to create one unless the proportion of residents with SARS-CoV-2 infection

makes this impossible (e.g., the majority of residents in the facility are already infected).

- The location of the COVID-19 care unit should ideally be physically separated from other rooms or units housing residents without confirmed SARS-CoV-2 infection. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with SARS-CoV-2 infection.
- Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. If possible, HCP should avoid working on both the COVID-19 care unit and other units during the same shift.
  - To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit.
  - Ideally, environmental services (EVS) staff should be dedicated to this unit, but to the extent possible, EVS staff should avoid working on both the COVID-19 care unit and other units during the same shift.
  - To the extent possible, HCP dedicated to the COVID-19 care unit (e.g., NAs and nurses) will also be performing cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. HCP should bring an Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from [List N](#)  into the room and wipe down high-touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room.
- HCP working on the COVID-19 care unit should have access to a restroom, break room, and work area that are separate from HCP working in other areas of the facility.
  - Ensure HCP practice source control measures and physical distancing in the break room and other common areas (i.e., other than while eating, HCP wear a respirator or source control and sit at least 6 feet apart while on break).
  - Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift).
- [CDC PPE optimization strategies](#) should be followed during shortages. Guidance addressing placement, duration, and recommended PPE when caring for residents with SARS-CoV-2 infection is described in [Section: Manage Residents with Suspected or Confirmed SARS-CoV-2 infection](#).

Older adults with SARS-CoV-2 infection may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures  $>99.0^{\circ}\text{F}$  might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for SARS-CoV-2 infection.

#### Evaluate Residents at least Daily

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
- Actively monitor all residents upon admission and at least daily for fever (temperature  $\geq 100.0^{\circ}\text{F}$ ) and [symptoms consistent with COVID-19](#). Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement precautions described in the section: [Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection](#).
  - Refer to [CDC resources](#)  for performing respiratory infection surveillance in long-term care facilities during an outbreak.
- Information about the clinical presentation and course of patients with SARS-CoV-2 infection is described in the [Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 \(COVID-19\)](#). CDC has also developed [Testing Guidelines for Nursing Homes](#).

#### Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection

- Residents with suspected SARS-CoV-2 infection should be prioritized for testing.
- Residents with suspected or confirmed SARS-CoV-2 infection do not need to be placed into an airborne infection isolation room (AIIR) but should be cared for HCP using an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown.
  - [CDC PPE optimization strategies](#) include a hierarchy of strategies to implement when PPE are in short supply or unavailable (e.g., use of a respirator approved under standards used in other countries that are similar to

NIOSH-approved N95 filtering facepiece respirators or a [well-fitting facemask](#) when NIOSH-approved N95 or equivalent or higher-level respirators are not available).

- Ideally a resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending.
  - In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit. However, in some circumstances (e.g., memory care units), keeping the door closed may pose resident safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway.
- If limited single rooms are available or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should shelter-in-place at their current location pending return of test results.
- Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection.
- Roommates of residents with SARS-CoV-2 infection should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents while they are in quarantine (i.e., for the 14 days following the date their roommate was moved to the COVID-19 care unit).
- Increase monitoring of residents with suspected or confirmed SARS-CoV-2 infection, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.
- For decisions on removing residents who have had SARS-CoV-2 infection from Transmission-Based Precautions refer to the [Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19](#).

If a resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions, the resident should be transferred to another facility that is capable of implementation. Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.

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## Managing Residents with Close Contact

### Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection

- Residents who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine for 14 days after their exposure.
- Residents in quarantine should be placed in a single-person room. If limited single rooms are available or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should shelter-in-place at their current location while being monitored for evidence of SARS-CoV-2 infection.
  - Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection. Placing a resident without confirmed SARS-CoV-2 infection (i.e., with symptoms concerning for COVID-19 pending testing or with known exposure) in a dedicated COVID-19 care unit could put them at higher risk of exposure to SARS-CoV-2.
- HCP should wear an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.
  - [CDC PPE optimization strategies](#) include a hierarchy of strategies to implement when PPE are in short supply or unavailable (e.g., use of a respirator approved under standards used in other countries that are similar to

NIOSH-approved N95 filtering facepiece respirators or a [well-fitting facemask](#) when NIOSH-approved N95 or equivalent or higher-level respirators are not available).

- Residents can be transferred out of quarantine if they remain with no fever and without symptoms for 14 days.
  - Alternatives to the 14-day quarantine period are described in the [Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing](#). Healthcare facilities could consider these alternatives as a measure to mitigate staffing shortages, space limitations, or PPE supply shortages but, due to the special nature of healthcare settings (e.g., patients at risk for worsening outcomes, critical nature of HCP, challenges with physical distancing), they are not the preferred option. Healthcare facilities should understand that shortening the duration of quarantine might pose additional transmission risk.

Guidance addressing quarantine and testing during an outbreak is described in Section: [Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident](#).

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## New Admissions and Residents who Leave the Facility

### Create a Plan for Managing New Admissions and Readmissions

- Residents with confirmed SARS-CoV-2 infection who have not met [criteria for discontinuation of Transmission-Based Precautions](#) should be placed in the designated COVID-19 care unit.
- In general, all other new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission.
  - Exceptions include residents within 3 months of a SARS-CoV-2 infection and fully vaccinated residents as described in CDC's [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#).
  - Facilities located in areas with minimal to no community transmission might elect to use a risk-based approach for determining which residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to IPC practices in healthcare settings, during transportation, or in the community prior to admission.

Guidance addressing placement, duration, and recommended PPE when caring for residents in quarantine is described in Section: [Manage Residents who have had Close Contact with Someone with SARS-CoV-2 Infection](#).

### Create a Plan for Residents who leave the Facility

- Residents who leave the facility should be reminded to follow all recommended IPC practices including source control, physical distancing, and hand hygiene and to encourage those around them to do the same.
  - Individuals accompanying residents (e.g., transport personnel, family members) should also be educated about these IPC practices and should assist the resident with adherence.
- For residents going to medical appointments, regular communication between the medical facility and the nursing home (in both directions) is essential to help identify residents with potential exposures or symptoms of COVID-19 before they enter the facility so that proper precautions can be implemented.
- In most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) and do not have close contact with someone with SARS-CoV-2 infection.
  - Quarantining residents who regularly leave the facility for medical appointments (e.g., dialysis, chemotherapy) would result in indefinite isolation of the resident that likely outweighs any potential benefits

of quarantine.

- Facilities might consider quarantining residents who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended IPC measures.
- Residents who leave the facility for 24 hours or longer should generally be managed as described in the [New Admission and Readmission](#) section.

Guidance addressing placement, duration, and recommended PPE when caring for residents in quarantine is described in [Section: Manage Residents who have had Close Contact with Someone with SARS-CoV-2 Infection](#).

This guidance summarizes the core infection prevention and control practices for nursing homes during the SARS-CoV-2 pandemic. Some of these recommendations can be modified in response to COVID-19 vaccination. Those modifications, which will be regularly updated, are posted in CDC's [Updated Healthcare Infection Prevention and Control Recommendations In Response to COVID-19 Vaccination](#).

## New Infection in Healthcare Personnel or Resident

### Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident

- Because of the high risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a [nursing home-onset](#) SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak.
  - Consider increasing monitoring of all residents from daily to every shift to more rapidly detect those with new symptoms.
- Implement [facility-wide testing](#) along with the following recommended infection prevention precautions:
  - HCP should care for residents using an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown.
  - Residents should generally be restricted to their rooms and [serial SARS-CoV-2 testing](#) performed.
  - Consideration should be given to halting social activities and communal dining; if these activities must continue for uninfected residents, they should be conducted using source control and physical distancing for all participants.
  - Guidance about visitation during facility outbreaks is available from [CMS](#)  [link](#) . Residents could leave their rooms to permit visitation; visitors should be informed about the outbreak in order to make informed decisions about visitation.
  - For additional information about visitation, see section: [Have a Plan for Visitation and CMS visitation memo](#)  [link](#) .
  - [Restrict non-essential HCP](#)  [link](#) for areas where [CMS limits indoor visitation](#)  [link](#) .
    - Consider implementing telehealth to offer remote access to healthcare.
- Continue [repeat viral testing](#) of all previously negative residents in addition to testing of HCP, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result.
- Recommended precautions should be continued for residents until no new cases of SARS-CoV-2 infection have been identified for at least 14 days.
- The incubation period for SARS-CoV-2 infection can be up to 14 days and the identification of a new case within that period after starting the interventions does not necessarily represent a failure of the interventions implemented to control transmission.

### Considerations for Residents and HCP who are within 3 months of prior infection

- [CDC currently recommends](#) that asymptomatic residents who have recovered and are within 3 months of a positive test for SARS-CoV-2 infection may not need to be quarantined or tested following re-exposure to someone with SARS-CoV-2 infection. However, there might be clinical scenarios in which the uncertainty about a prior infection or the durability of the immune response exist, for which providers could consider testing for SARS-CoV-2 and quarantine following exposure that occurs less than 3 months after their initial infection, Examples could include:

- Residents with underlying immunocompromising conditions (e.g., patient after organ transplantation) or who become immune compromised (e.g., receive chemotherapy) in the 3 months following SARS-CoV-2 infection and who might have an increased risk for reinfection. However, data on which specific conditions may lead to higher risk and the magnitude of risk are not available.
- Residents for whom there is concern that their initial diagnosis of SARS-CoV-2 infection might have been based on a false positive test result (e.g., resident was asymptomatic, antigen test positive, and a confirmatory nucleic acid amplification test (NAAT) was not performed).
- Residents for whom there is evidence that they were exposed to a novel SARS-CoV-2 variant (e.g., exposed to a person known to be infected with a novel variant) for which the risk of reinfection might be higher.

CDC continues to actively investigate the frequency of reinfection and the circumstances surrounding these episodes, including the role that new variants might play in reinfection, and will adjust guidance as necessary as more information becomes available.

## Definitions

**Healthcare Personnel (HCP):** HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

**Healthcare settings:** Places where healthcare is delivered and includes, but is not limited to, acute care facilities, long term acute care facilities, inpatient rehabilitation facilities, nursing homes and assisted living facilities, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, and others.

**Source Control:** Use of well-fitting cloth masks, facemasks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Cloth masks, facemasks, and respirators should not be placed on children under age 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing a cloth mask, facemask, or respirator safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their cloth mask, facemask, or respirator without assistance. Face shields alone are not recommended for source control.

**Cloth mask:** Textile (cloth) covers that are intended primarily for source control. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel as the degree to which cloth masks protect the wearer is unclear. Guidance on design, use, and maintenance of cloth masks is available.

**Facemask:** Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

**Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.

**Minimal to no community transmission of SARS-CoV-2:** Sustained transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases

**Substantial community transmission of SARS-CoV-2:** Large scale community transmission, including communal settings (e.g., schools, workplaces)

**Close Contact:** Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period\* starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated.

\*Individual exposures added together over a 24-hour period (e.g., three 5-minute exposures for a total of 15 minutes). Data are limited, making it difficult to precisely define "close contact;" however, 15 cumulative minutes of exposure at a distance of 6 feet or less can be used as an operational definition for contact investigation. Factors to consider when defining close contact include proximity (closer distance likely increases exposure risk), the duration of exposure (longer exposure time likely increases exposure risk), whether the infected individual has symptoms (the period around onset of symptoms is associated with the highest levels of viral shedding), if the infected person was likely to generate respiratory aerosols (e.g., was coughing, singing, shouting), and other environmental factors (crowding, adequacy of ventilation, whether exposure was indoors or outdoors). Because the general public has not received training on proper selection and use of respiratory PPE, such as an N95, the determination of close contact should generally be made irrespective of whether the contact was wearing respiratory PPE. At this time, differential determination of close contact for those using fabric face coverings is not recommended.

- Information about risk assessment and work restrictions for HCP exposed to SARS-CoV-2 is available in the [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to Coronavirus Disease 2019 \(COVID-19\)](#).
- Risk assessment considerations for residents who are exposed in a healthcare setting is available in the [FAQs for Infection Control](#)

## More Information

Considerations for Memory Care Units in Long-Term Care Facilities

[Long-term Care Facility Letter](#)  to Residents, Families, Friends and Volunteers

Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

[CMS Emergency Preparedness & Response Operations](#) 

Long-Term Care Facility Toolkit: Preparing for COVID-19 Vaccination at Your Facility

[Supporting Your Loved One in a Long-Term Care Facility](#)  [472 KB, 1 page]

NHSN LTCF Weekly HCP & Resident COVID-19 Vaccination Reporting

[Infection Prevention Success Stories](#)

Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination

[Applying COVID-19 Infection Prevention and Control Strategies in Nursing Homes \(Recorded Webinar\)](#)

Sample Notification Letter to Residents and Families: COVID-19 Transmission Identified [PDF](#)  | [DOC](#) 

[COVID-19 Data Tracker Integrated County View](#)

## References

- [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#)
- [Council of State and Territorial Epidemiologists \(CSTE\) Proposed Investigation/Reporting Thresholds and Outbreak Definitions for COVID-19 in Healthcare Settings](#)  
- [CMS Nursing Home Reopening Guidance for State and Local Officials](#)   Memorandum
- [CMS Nursing Home Visitation COVID-19 Memorandum](#)  
- [OSHA PPE standards \(29 CFR 1910 Subpart I\)](#) 
- [Optimizing Supply of PPE and Other Equipment during Shortages](#)
- [Improve the Fit and Filtration of Your Mask to Reduce the Spread of COVID-19](#)

- Testing Guidelines for Nursing Homes
- Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2
- SARS-CoV-2 Antigen Testing in Long Term Care Facilities
- Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings
- Return to Work Criteria for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)
- Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2
- Strategies to Mitigate Healthcare Personnel Staffing Shortages
- Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 (COVID-19)
- Discontinuation of Transmission-Based Precautions and Disposition of Patients with SARS-CoV-2 Infection in Healthcare Settings
- Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing

Last Updated Mar. 29, 2021



**Center for Clinical Standards and Quality/Survey & Certification Group**

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**DATE:** August 26, 2020

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

Ref: QSO-20-38-NH  
**REVISED 04/27/2021**

**SUBJECT: Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements and Revised COVID-19 Focused Survey Tool**

**Memorandum Summary**

- CMS is committed to taking critical steps to ensure America's healthcare facilities continue to respond effectively to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- On August 25, 2020, CMS published an interim final rule with comment period (IFC). This rule establishes **Long-Term Care (LTC) Facility Testing Requirements for Staff and Residents**. Specifically, facilities are required to test residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19 based on parameters set forth by the HHS Secretary. This memorandum provides guidance for facilities to meet the new requirements.
- **Revised COVID-19 Focused Survey Tool** - To assess compliance with the new testing requirements, CMS has revised the survey tool for surveyors. We are also adding to the survey process the assessment of compliance with the requirements for facilities to designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility's infection prevention and control program (IPCP) at 42 CFR § 483.80(b). In addition, we are making a number of revisions to the survey tool to reflect other COVID-19 guidance updates.

On August 25, 2020, CMS published an interim final rule with comment period (IFC), CMS-3401-IFC, entitled "[Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments of 1988 \(CLIA\), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency](#)".

CMS's recommendation below to test with authorized nucleic acid or antigen detection assays is an important addition to other infection prevention and control (IPC) recommendations aimed at preventing COVID-19 from entering nursing homes, detecting cases quickly, and stopping transmission. Swift identification of confirmed COVID-19 cases allows the facility to take immediate action to remove exposure risks to nursing home residents and staff. CMS has added

42 CFR § 483.80(h) which requires that the facility test all residents and staff for COVID-19. Guidance related to the requirements is located below. Noncompliance related to this new requirement will be cited at new tag F886.

### § 483.80 Infection control

\* \* \* \* \*

§ 483.80(h) *COVID-19 Testing*. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:

- (1) Conduct testing based on parameters set forth by the Secretary, including but not limited to:
  - (i) Testing frequency;
  - (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;
  - (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;
  - (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
  - (v) The response time for test results; and
  - (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.
- (2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;
- (3) For each instance of testing:
  - (i) Document that testing was completed and the results of each staff test; and
  - (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.
- (4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.
- (5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.
- (6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.

F886

### ***DEFINITIONS***

*“Fully vaccinated” refers to a person who is  $\geq 2$  weeks following receipt of the second dose in a 2-dose series, or  $\geq 2$  weeks following receipt of one dose of a single-dose vaccine.*

*“Unvaccinated” refers to a person who does not fit the definition of “fully vaccinated,” including people whose vaccination status is not known, for the purposes of this guidance.*

## **GUIDANCE**

### **Testing of Nursing Home Staff and Residents**

To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary.

Facilities can meet the testing requirements through the use of rapid point-of-care (POC) diagnostic testing devices or through an arrangement with an offsite laboratory. POC Testing is diagnostic testing that is performed at or near the site of resident care. For a facility to conduct these tests with their own staff and equipment (including POC devices provided by the Department of Health and Human Services), the facility must have a CLIA Certificate of Waiver. Information on obtaining a CLIA Certificate of Waiver can be found [here](#).

Facilities without the ability to conduct COVID-19 POC testing should have arrangements with a laboratory to conduct tests to meet these requirements. Laboratories that can quickly process large numbers of tests with rapid reporting of results (e.g., within 48 hours) should be selected to rapidly inform infection prevention initiatives to prevent and limit transmission.

“**Facility staff**” includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility’s nurse aide training programs or from affiliated academic institutions. For the purpose of testing “individuals providing services under arrangement and volunteers,” facilities should prioritize those individuals who are regularly in the facility (e.g., weekly) and have contact with residents or staff. We note that the facility may have a provision under its arrangement with a vendor or volunteer that requires them to be tested from another source (e.g., their employer or on their own). However, the facility is still required to obtain documentation that the required testing was completed during the timeframe that corresponds to the facility’s testing frequency, as described in Table 2 below.

Regardless of the frequency of testing being performed or the facility’s COVID-19 status, the facility should continue to screen all staff (each shift), each resident (daily), and all persons entering the facility, such as vendors, volunteers, and visitors, for signs and symptoms of COVID-19.

When prioritizing individuals to be tested, facilities should prioritize individuals with signs and symptoms of COVID-19 first, then perform testing triggered by an outbreak (as specified below).

**Table 1: Testing Summary**

<b>Testing Trigger</b>	<b>Staff</b>	<b>Residents</b>
Symptomatic individual identified	Staff, <i>vaccinated and unvaccinated</i> , with signs and symptoms must be tested	Residents, <i>vaccinated and unvaccinated</i> , with signs and symptoms must be tested

Outbreak (Any new case arises in facility)	Test all staff, <i>vaccinated and unvaccinated</i> , that previously tested negative until no new cases are identified*	Test all residents, <i>vaccinated and unvaccinated</i> , that previously tested negative until no new cases are identified*
Routine testing	According to Table 2 below	Not recommended, unless the resident leaves the facility routinely.

\*For outbreak testing, all staff and residents should be tested, *regardless of vaccination status*, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. For more information, please review the section below titled, “Testing of Staff and Residents in Response to an Outbreak.”

**Testing of Staff and Residents with COVID-19 Symptoms or Signs**

Staff with symptoms or signs of COVID-19, *vaccinated or not vaccinated*, must be tested *immediately* and are expected to be restricted from the facility pending the results of COVID-19 testing. If COVID-19 is confirmed, staff should follow Centers for Disease Control and Prevention (CDC) guidelines “[Criteria for Return to Work for Healthcare Personnel with SARS-CoV2 Infection.](#)” Staff who do not test positive for COVID-19 but have symptoms should follow facility policies to determine when they can return to work.

Residents who have signs or symptoms of COVID-19, *vaccinated or not vaccinated*, must be tested *immediately*. While test results are pending, residents with signs or symptoms should be placed on transmission-based precautions (TBP) in accordance with [CDC guidance](#). Once test results are obtained, the facility must take the appropriate actions based on the results.

Note: Concerns related to initiating and/or maintaining TBP should be investigated under F880, Infection Control.

**Testing of Staff and Residents with an Exposure**

*For information on testing staff and resident who may have been exposed to COVID-19, see the CDC’s [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination.](#)*

**Testing of Staff and Residents in Response to an Outbreak**

An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any [nursing home-onset](#) COVID-19 infection in a resident. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. A resident who is admitted to the facility with COVID-19 does not constitute a facility outbreak.

Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents, *regardless of vaccination status*, should be tested *immediately*, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. See CDC guidance “Testing Guidelines for Nursing Homes” section [Non-diagnostic testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2.](#)

For individuals who test positive for COVID-19, repeat testing is not recommended. A symptom-based strategy is intended to replace the need for repeated testing. Facilities should follow the CDC guidance [Discontinuation of Transmission-Based Precautions and Disposition of Patients with SARS-CoV-2 Infection in Healthcare Settings](#) for residents and [Criteria for Return to Work for Healthcare Personnel with SARS-CoV2 Infection](#).

### **Routine Testing of Staff**

Routine testing *of unvaccinated staff* should be based on the extent of the virus in the community. *Fully vaccinated staff do not have to be routinely tested.* Facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency. Reports of COVID-19 county-level positivity rates *are* available on the following website (see section titled, “COVID-19 Testing”): <https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg>

**Table 2: Routine Testing Intervals Vary by Community COVID-19 Activity Level**

<b>Community COVID-19 Activity</b>	<b>County Positivity Rate in the past week</b>	<b>Minimum Testing Frequency of Unvaccinated Staff<sup>†</sup></b>
<b>Low</b>	<b>&lt;5%</b>	<b>Once a month</b>
<b>Medium</b>	<b>5% - 10%</b>	<b>Once a week*</b>
<b>High</b>	<b>&gt;10%</b>	<b>Twice a week*</b>

<sup>†</sup>*Vaccinated staff do not need be routinely tested.*

\*This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.

If the 48-hour turn-around time cannot be met due to community testing supply shortages, limited access or inability of laboratories to process tests within 48 hours, the facility should have documentation of its efforts to obtain quick turnaround test results with the identified laboratory or laboratories and contact with the local and state health departments.

The facility should *test* all *unvaccinated* staff at the frequency prescribed in the Routine Testing table based on the county positivity rate reported *in* the past week. Facilities should monitor their county positivity rate every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table above.

- If the county positivity rate increases to a higher level of activity, the facility should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity are met.
- If the county positivity rate decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the county positivity rate has remained at the lower activity level for at least two weeks before reducing testing frequency.

The guidance above represents the minimum testing expected. Facilities may consider other factors, such as the positivity rate in an adjacent (i.e., neighboring) county to test at a frequency that is higher than required. For example, if a facility in a county with low a positivity rate has many staff that live in a county with a medium positivity rate, the facility should consider testing based on the higher positivity rate (in scenario described, weekly staff testing would be indicated).

State and local officials may also direct facilities to monitor other factors that increase the risk for COVID-19 transmission, such as rates of Emergency Department visits of individuals with COVID-19-like symptoms. Facilities should consult with state and local officials on these factors, and the actions that should be taken to reduce the spread of the virus.

<https://www.cdc.gov/covid-data-tracker/index.html#ed-visits>.

NOTE: Routine testing of asymptomatic residents is not recommended unless prompted by a change in circumstances, such as the identification of a confirmed COVID-19 case in the facility. Facilities may consider testing asymptomatic residents who leave the facility frequently, such as for dialysis or chemotherapy. Facilities should inform resident transportation services (such as non-emergency medical transportation) and receiving healthcare providers (such as hospitals) regarding a resident's COVID-19 status to ensure appropriate infection control precautions are followed.

Routine communication between the nursing home and other entities about the resident's status should ideally occur prior to the resident leaving the nursing home for treatment. Coordination between the nursing home and the other healthcare entity is vital to ensure healthcare staff are informed of the most up to date information relating to the resident's health status, including COVID-19 status, and to allow for proper planning of care and operations. Additionally, facilities should maintain communications with the local ambulance and other contracted providers that transport residents between facilities, to ensure appropriate infection control precautions are followed as described by the CDC.

### **Refusal of Testing**

Facilities must have procedures in place to address staff who refuse testing. Procedures should ensure that staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met. If outbreak testing has been triggered and a staff member refuses testing, the staff member should be restricted from the building until the procedures for outbreak testing have been completed. The facility should follow its occupational health and local jurisdiction policies with respect to any asymptomatic staff who refuse routine testing.

Residents (or resident representatives) may exercise their right to decline COVID-19 testing in accordance with the requirements under 42 CFR § 483.10(c)(6). In discussing testing with residents, staff should use person-centered approaches when explaining the importance of testing for COVID-19. Facilities must have procedures in place to address residents who refuse testing. Procedures should ensure that residents who have signs or symptoms of COVID-19 and refuse testing are placed on TBP until the criteria for discontinuing TBP have been met. If outbreak testing has been triggered and an asymptomatic resident refuses testing, the facility should be extremely vigilant, such as through additional monitoring, to ensure the resident maintains appropriate distance from other residents, wears a face covering, and practices effective hand hygiene until the procedures for outbreak testing have been completed.

Clinical discussions about testing may include alternative specimen collection sources that may be more acceptable to residents than nasopharyngeal swabs (e.g., anterior nares). Providing information about the method of testing and reason for pursuing testing may facilitate discussions with residents or resident representatives.

If a resident has symptoms consistent with COVID-19 or has been exposed to COVID-19, or if there is a facility outbreak and the resident declines testing, he or she should be placed on or remain on TBP until he or she meets the symptom-based criteria for discontinuation.

### **Other Testing Considerations**

In keeping with current CDC recommendations staff and residents who have recovered from COVID-19 and are asymptomatic do not need to be retested for COVID-19 within 3 months after symptom onset. Until more is known, testing should be encouraged again (e.g., in response to an exposure) 3 months after the date of symptom onset with the prior infection. Facilities should continue to monitor the CDC webpages and FAQs for the latest information. The facility should consult with infectious diseases specialists and public health authorities to review all available information (e.g., medical history, time from initial positive test, Reverse Transcription-Polymerase Chain Reaction Cycle Threshold (RT-PCR Ct) values, and presence of COVID-19 signs or symptoms). Individuals who are determined to be potentially infectious should undergo evaluation and remain isolated until they meet criteria for discontinuation of isolation or discontinuation of transmission-based precautions, depending on their circumstances.

For residents or staff who test positive, facilities should contact the appropriate state or local entity for contact tracing.

While not required, facilities may test residents' visitors to help facilitate visitation while also preventing the spread of COVID-19. Facilities should prioritize resident and staff testing and have adequate testing supplies to meet required testing, prior to testing resident visitors.

### **Conducting Testing**

In accordance with 42 CFR § 483.50(a)(2)(i), the facility must obtain an order from a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with State law, including scope of practice laws to provide or obtain laboratory services for a resident, which includes COVID-19 testing (see F773). This may be accomplished through the use of physician approved policies (e.g., standing orders), or other means as specified by scope of practice laws and facility policy.

NOTE: Concerns related to orders for laboratory and/or POC testing should be investigated under F773.

Rapid POC Testing devices are prescription use tests under the Emergency Use Authorization and must be ordered by a healthcare professional licensed under the applicable state law or a pharmacist under HHS guidance. Accordingly, the facility must have an order from a healthcare professional or pharmacist, as previously described, to perform a rapid POC COVID-19 test on an individual.

Facilities must conduct testing according to nationally recognized guidelines, outlined by the Centers for Disease Control and Prevention (CDC). This would include the following guidelines:

- Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes:  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>
- Testing Guidelines for Nursing Homes:  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

- Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2:  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html>.

A diagnostic test shows if a patient has an active coronavirus infection. As of the date of this guidance, there are two types of diagnostic tests which detect the active virus – molecular tests, such as RT-PCR tests, that detect the virus’s genetic material, and antigen tests that detect specific proteins on the surface of the virus. An antibody test looks for antibodies that are made by the immune system in response to a threat, such as a specific virus. An antibody test does not identify an active coronavirus infection; therefore, conducting an antibody test on a staff or resident would not meet the requirements under this regulation.

Frequently asked questions related to the use of these testing devices in high-risk congregate settings such as nursing homes can be found [here](#). In addition, when testing residents, a facility’s selection of a test should be person-centered.

Collecting and handling specimens correctly and safely is imperative to ensure the accuracy of test results and prevent any unnecessary exposures. The specimen should be collected and, if necessary, stored in accordance with the manufacturer’s instructions for use for the test and CDC guidelines.

During specimen collection, facilities must maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens.

The CDC has provided guidance on proper specimen collection:

- Influenza Specimen Collection: <https://www.cdc.gov/flu/pdf/professionals/flu-specimen-collection-poster.pdf>.
- Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19):  
(<https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html>).
- CDC’s Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Coronavirus Disease 2019 (COVID-19):  
<https://www.cdc.gov/coronavirus/2019-ncov/lab/lab-biosafety-guidelines.html>.

For additional considerations for antigen testing, see CDC’s [Interim Guidance for Rapid Antigen Testing for SARS-CoV-2](#).

As a reminder, per 42 CFR § 483.50(a), the facility must provide or obtain laboratory services to meet the needs of its residents. If a facility provides its own laboratory services or performs any laboratory tests directly (e.g., SARS-CoV-2 point-of-care test) the provisions of 42 CFR Part 493 apply and the facility must have a current CLIA certificate appropriate for the level of testing performed within the facility. Surveyors should only verify that the facility has a current CLIA certificate and not attempt to determine compliance with the requirements in 42 CFR Part 493.

### **Reporting Test Results**

Facilities conducting tests under a CLIA certificate of waiver are subject to regulations that require laboratories to report data for all testing completed, for each individual tested. For additional information on reporting requirements see:

- [Frequently Asked Questions: COVID-19 Testing at Skilled Nursing Facilities/Nursing Homes](#)
- CMS memorandum: [Interim Final Rule \(IFC\), CMS-3401-IFC, Updating Requirements for Reporting of SARS-CoV-2 Test Results by Clinical Laboratory Improvement Amendments of 1988 \(CLIA\) Laboratories, and Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency](#)

Surveyors should report concerns related to CLIA certificates or laboratory reporting requirements to the CMS Division of Clinical Laboratory Improvement and Quality at [LabExcellence@cms.hhs.gov](mailto:LabExcellence@cms.hhs.gov). When reporting concerns include the CLIA number; name and address of laboratory (facility); number of days that results were not reported, if known; and number of results not reported, if known.

In addition to reporting in accordance with CLIA requirements, facilities must continue to report COVID-19 information to the CDC's National Healthcare Safety Network (NHSN), in accordance with 42 CFR § 483.80(g)(1)–(2). See “Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes,” CMS Memorandum [QSO-20-29-NH \(May 6, 2020\)](#).

NOTE: Concerns related to informing residents, their representatives and families of new or suspected cases of COVID-19 should be investigated under F885.

NOTE: Concerns related to the reporting to state and local public health authority of communicable diseases and outbreaks, including for purposes such as contact tracing, should be investigated under F880.

### **Documentation of Testing**

Facilities must demonstrate compliance with the testing requirements. To do so, facilities should do the following:

- For symptomatic residents and staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results.
- Upon identification of a new COVID-19 case in the facility (i.e., outbreak), document the date the case was identified, the date that all other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests. All residents and staff that tested negative are expected to be retested until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result (see section Testing of Staff and Residents in response to an outbreak above).
- For staff routine testing, document the facility's county positivity rate, the corresponding testing frequency indicated (e.g., every other week), and the date each positivity rate was collected. Also, document the date(s) that testing was performed for all staff, and the results of each test.
- Document the facility's procedures for addressing residents and staff that refuse testing or are unable to be tested, and document any staff or residents who refused or were unable to be tested and how the facility addressed those cases.

- When necessary, such as in emergencies due to testing supply shortages, document that the facility contacted state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.

Facilities may document the conducting of tests in a variety of ways, such as a log of county positivity rates, schedules of completed testing, and/or staff and resident records. However, the results of tests must be done in accordance with standards for protected health information. For residents, the facility must document testing results in the medical record. For staff, including individuals providing services under arrangement and volunteers, the facility must document testing results in a secure manner consistent with requirements specified in 483.80(h)(3).

### **Surveying for Compliance**

Compliance will be assessed through the following process using the COVID-19 Focused Survey for Nursing Homes:

1. Surveyors will ask for the facility's documentation noted in the "Documentation of Testing" section above, and review the documentation for compliance.
2. Surveyors will also review records of those residents and staff selected as a sample as part of the survey process.
3. If possible, surveyors should observe how the facility conducts testing in real-time. In this process, surveyors will assess if the facility is conducting testing and specimen collection in a manner that is consistent with current standards of practice for conducting COVID-19 tests, such as ensuring PPE is used correctly to prevent the transmission of the virus. If observation is not possible, surveyors should interview an individual responsible for testing and inquire on how testing is conducted (e.g., "what are the steps taken to conduct each test?").
4. If the facility has a shortage of testing supplies, or cannot obtain test results within 48 hours, the surveyor should ask for documentation that the facility contacted state and local health departments to assist with these issues.

Facilities that do not comply with the testing requirements in § 483.80(h) will be cited for noncompliance at F886. Additionally, enforcement remedies (such as civil money penalties) will be imposed based on the resident outcome (i.e., the scope and severity of the noncompliance), in accordance with Chapter 7 of the State Operations Manual.

If the facility has documentation that demonstrates their attempts to perform and/or obtain testing in accordance with these guidelines (e.g., timely contacting state officials, multiple attempts to identify a laboratory that can provide testing results within 48 hours), surveyors should not cite the facility for noncompliance. Surveyors should also inform the state or local health authority of the facility's lack of resources.

CMS is also continuing to assess automated methods for determining compliance with the testing requirements, which may augment the assessment of compliance through onsite surveys.

### **Additional Resource Links:**

- Clinical Questions about COVID-19: Questions and Answers-Testing in Nursing Homes  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Testing-in-Nursing-Homes>
- Nursing Home Reopening Recommendations for State and Local Officials  
<https://www.cms.gov/files/document/qso-20-30-nh.pdf-0>

- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings  
<https://www.cdc.gov/coronavirus/2019-ncov/hep/disposition-hospitalized-patients.html>

**COVID-19 Focused Survey for Nursing Homes**

CMS revised the COVID-19 Focused Survey for Nursing Homes tool to reflect the new testing requirements implemented in the IFC. *The current Survey/Infection Prevention, Control & Immunization Pathway (CMS-20054) can be found in the LTC Survey Pathways zipfile located at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTC-Survey-Pathways.zip>.*

**Contact:** Questions related to the nursing home testing requirement may be submitted to: [DNH\\_TriageTeam@cms.hhs.gov](mailto:DNH_TriageTeam@cms.hhs.gov).

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers and the State Agency/CMS Branch Location training coordinators immediately.

/s/  
David R. Wright

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
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**Center for Clinical Standards and Quality/Survey & Certification Group**

Ref: QSO-20-39-NH

**REVISED 04/27/2021**

**DATE:** September 17, 2020

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Nursing Home Visitation - COVID-19 (**REVISED**)

**Memorandum Summary**

- CMS is committed to continuing to take critical steps to ensure America's healthcare facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- **Visitation Guidance:** CMS is issuing new guidance for visitation in nursing homes during the COVID-19 PHE, including the impact of COVID-19 vaccination.

**Background**

Nursing homes have been severely impacted by COVID-19, with outbreaks causing high rates of infection, morbidity, and mortality.<sup>1</sup> The vulnerable nature of the nursing home population combined with the inherent risks of congregate living in a healthcare setting have required aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within nursing homes.

In March 2020, CMS issued memorandum [QSO-20-14-NH](#) providing guidance to facilities on restricting visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In May 2020, CMS released [Nursing Home Reopening Recommendations](#), which provided additional guidance on visitation for nursing homes as their states and local communities progress through the phases of reopening.

While CMS guidance has focused on protecting nursing home residents from COVID-19, we recognize that physical separation from family and other loved ones has taken a physical and emotional toll on residents and their loved ones. Residents may feel socially isolated, leading to increased risk for depression, anxiety, and other expressions of distress. Residents living with cognitive impairment or other disabilities may find visitor restrictions and other ongoing changes related to COVID-19 confusing or upsetting. CMS understands that nursing home residents derive

<sup>1</sup> Information on outbreaks and deaths in nursing homes may be found at <https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg>.

value from the physical, emotional, and spiritual support they receive through visitation from family and friends. In light of this, CMS is revising the guidance regarding visitation in nursing homes during the COVID-19 PHE. The information contained in this memorandum supersedes and replaces previously issued guidance and recommendations regarding visitation.

Since the release of QSO memorandum 20-39-NH on September 17, 2020, COVID-19 vaccines have received Emergency Use Authorization from the Food and Drug Administration. Millions of vaccinations have since been administered to nursing home residents and staff, and these vaccines have been shown to help prevent symptomatic SARS-CoV-2 infection (i.e., COVID-19).

**Therefore, CMS, in conjunction with the Centers for Disease Control and Prevention (CDC), is updating its visitation guidance accordingly, but emphasizing the importance of maintaining infection prevention practices, given the continued risk of COVID-19 transmission.**

### **Guidance**

Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission:

#### **Core Principles of COVID-19 Infection Prevention**

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status)
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose) and social distancing at least six feet between persons, *in accordance with CDC guidance*
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR § 483.80(h) (see QSO-20-38-NH Revised)

These core principles are consistent with the Centers for Disease Control and Prevention (CDC guidance) for nursing homes, and should be **adhered to at all times**. Additionally, visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. The risk of transmission can be further reduced through the use of physical barriers (e.g., clear Plexiglass dividers, curtains). Also, nursing homes should enable visits to be conducted with an adequate degree of privacy. Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles,

visitation can occur safely based on the below guidance.

### **Outdoor Visitation**

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred even when the resident and visitor are fully vaccinated\* against COVID-19. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. Therefore, visits should be held outdoors whenever practicable. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status, *quarantine status*) may hinder outdoor visits. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, all appropriate infection control and prevention practices should be adhered to.

\*Fully vaccinated refers to a person who is  $\geq 2$  weeks following receipt of the second dose in a 2-dose series, or  $\geq 2$  weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons.

### **Indoor Visitation**

*See the current CDC guidance at Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination for information on indoor visitation.*

Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times). These scenarios include limiting indoor visitation for:

- Unvaccinated residents, if the nursing home's COVID-19 county positivity rate is  $>10\%$  **and**  $<70\%$  of residents in the facility are fully vaccinated;<sup>2</sup>
- Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met the criteria to discontinue Transmission-Based Precautions; *or*
- Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

Facilities should consider how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention. If necessary, facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors. During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Visits for residents who share a room should not be conducted in the resident's room, if possible. For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.

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<sup>2</sup> The county positivity rate refers to the color-coded positivity classification, which can be found on the COVID-19 Nursing Home Data site.

**NOTE:** CMS and CDC continue to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection, including physical distancing (maintaining at least 6 feet between people). This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated. However, we acknowledge the toll that separation and isolation has taken. We also acknowledge that there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. Therefore, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor *in accordance with the CDC's Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination*. *Visitors* should physically distance from other residents and staff in the facility.

### **Indoor Visitation during an Outbreak**

An outbreak exists when a new nursing home onset of COVID-19 occurs (i.e., a new COVID-19 case among residents or staff). This guidance is intended to describe how visitation can still occur when there is an outbreak, but there is evidence that the transmission of COVID-19 is contained to a single area (e.g., unit) of the facility. To swiftly detect cases, we remind facilities to adhere to CMS regulations and guidance for COVID-19 testing, including routine staff testing, testing of individuals with symptoms, and outbreak testing.

When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing and suspend all visitation (except that required under federal disability rights law), until at least one round of facility-wide testing is completed. Visitation can resume based on the following criteria:

- If the first round of outbreak testing reveals **no additional COVID-19 cases in other areas (e.g., units) of the facility**, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing.<sup>3</sup>
  - For example, if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.
- If the first round of outbreak testing **reveals one or more additional COVID-19 cases in other areas/units of the facility** (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

While the above scenarios describe how visitation can continue after one round of outbreak testing, facilities should continue all necessary rounds of outbreak testing. In other words, this guidance provides information on how visitation can occur during an outbreak, but does not change any expectations for testing and adherence to infection prevention and control practices. If subsequent rounds of outbreak testing identify **one or more additional COVID-19 cases in other areas/units of the facility**, then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

NOTE: In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of

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<sup>3</sup> Outbreak testing is discontinued when testing identifies no new cases of COVID-19 infection among staff or residents for at least 14 days since the most recent positive result. For more information see [CMS Memorandum QSO-20-38-NH](#).

COVID-19 infection prevention, including effective hand hygiene and use of face-coverings.

We note that compassionate care visits and visits required under federal disability rights law should be **allowed at all times**, for any resident (vaccinated or unvaccinated) regardless of the above scenarios. Lastly, facilities should continue to consult with their state or local health departments when an outbreak is identified to ensure adherence to infection control precautions, and for recommendations to reduce the risk of COVID-19 transmission.

### **Visitor Testing and Vaccination**

While not required, we encourage facilities in medium- or high-positivity counties to offer testing to visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days). Similarly, we encourage visitors to become vaccinated when they have the opportunity. While visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation. This also applies to representatives of the Office of the State Long-Term Care Ombudsman and protection and advocacy systems, as described below.

### **Compassionate Care Visits**

While end-of-life situations have been used as examples of compassionate care situations, the term “compassionate care situations” does not exclusively refer to end-of-life situations.

Examples of other types of compassionate care situations include, but are not limited to:

- A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support.
- A resident who is grieving after a friend or family member recently passed away.
- A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
- A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

Allowing a visit in these situations would be consistent with the intent of, “compassionate care situations.” Also, in addition to family members, compassionate care visits can be conducted by any individual that can meet the resident’s needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included. Compassionate care visits, and visits required under federal disability rights law, should be allowed at all times, regardless of a resident’s vaccination status, the county’s COVID-19 positivity rate, or an outbreak.

Lastly, visits should be conducted using social distancing; however, if during a compassionate care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following appropriate infection prevention guidelines, and for a limited amount of time. Also, as noted above, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents and staff in the facility. Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits.

### **Required Visitation**

Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR § 483.10(f) (4) (v). A nursing home **must** facilitate in-person visitation consistent with the applicable CMS regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR § 483.10(f) (4), and the facility would be subject to citation and enforcement actions.

Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through windows, or in-person for compassionate care situations, with adherence to transmission-based precautions. However, this restriction should be lifted once transmission-based precautions are no longer required per CDC guidelines, and other visits may be conducted as described above.

### **Access to the Long-Term Care Ombudsman**

As stated in previous CMS guidance OSO-20-28-NH (revised), regulations at 42 CFR § 483.10(f)(4)(i)(C) require that a Medicare and Medicaid- certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. During this PHE, in-person access may be limited due to infection control concerns and/or transmission of COVID-19, such as the scenarios stated above for limiting indoor visitation; however, in-person access may not be limited without reasonable cause. We note that representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention as described above. If in-person access is deemed inadvisable (e.g., the Ombudsman has signs or symptoms of COVID-19), facilities must, at a minimum, facilitate alternative resident communication with the ombudsman, such as by phone or through use of other technology. Nursing homes are also required under 42 CFR § 483.10(h)(3)(ii) to allow the Ombudsman to examine the resident's medical, social, and administrative records as otherwise authorized by State law.

### **Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs**

Section 483.10(f)(4)(i)(E) and (F) requires the facility to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000). P&A programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to "investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system or if there is probable cause to believe the incidents occurred." 42 U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes "the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in person." 42 CFR § 51.42(c); 45 CFR § 1326.27.

Additionally, each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

For example, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention. Any questions about or issues related to enforcement or oversight of the non-CMS requirements and citations referenced above under this section subject heading should be referred to the HHS Office for Civil Rights, the Administration for Community Living, or other appropriate oversight agency.

### **Entry of Healthcare Workers and Other Providers of Services**

Health care workers who are not employees of the facility but provide direct care to the facility's residents, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy, etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or showing signs or symptoms of COVID-19 after being screened. We note that EMS personnel do not need to be screened, so they can attend to an emergency without delay. We remind facilities that all staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.

We understand that some states or facilities have designated categories of visitors, such as "essential caregivers," based on their visit history or resident designation. CMS does not distinguish between these types of visitors and other visitors. Using a person-centered approach when applying this guidance should cover all types of visitors, including those who have been categorized as "essential caregivers."

### **Communal Activities and Dining**

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. *The CDC has provided additional guidance on activities and dining based on resident vaccination status. For example, residents who are fully vaccinated may dine and participate in activities without face coverings or social distancing if all participating residents are fully vaccinated; if unvaccinated residents are present during communal dining or activities, then all residents should use face coverings when not eating and unvaccinated residents should physically distance from others. See the CDC guidance [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#) for information on communal dining and activities.*

### **Survey Considerations**

Federal and state surveyors are not required to be vaccinated and must be permitted entry into facilities unless they exhibit signs or symptoms of COVID-19. Surveyors should also adhere to the core principles of COVID-19 infection prevention, and adhere to any COVID-19 infection prevention requirements set by state law.

- For concerns related to resident communication with and access to persons and services inside and outside the facility, surveyors should investigate for non-compliance at 42

- CFR § 483.10(b), F550.
- For concerns related to a facility limiting visitors without a reasonable clinical and safety cause, surveyors should investigate for non-compliance at 42 CFR § 483.10(f)(4), F563.
  - For concerns related to ombudsman access to the resident and the resident's medical record, surveyors should investigate for non-compliance at 42 CFR §§ 483.10(f)(4)(i)(C), F562 and 483.10(h)(3)(ii), F583.
  - For concerns related to lack of adherence to infection control practices *including practices for residents and staff based on COVID-19 vaccination status*, surveyors should investigate for non-compliance at 42 CFR § 483.80(a), F880.

**Contact:** Questions related to this memorandum may be submitted to: [DNH\\_TriageTeam@cms.hhs.gov](mailto:DNH_TriageTeam@cms.hhs.gov).

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers, and the State/CMS Locations within 30 days of this memorandum.

/s/  
David R. Wright

cc: Survey Operations Group



### COVID-19 FACILITY REQUIREMENTS Temporary Structures

#### Fire Department Access

1. Fire department access roads must maintain a width of at least 20 feet wide and a vertical clearance that is unobstructed for a height that is at least 13'-6", for the whole distance of the access road. [NFPA 101: 18.2.3.4.1.1 & 18.2.3.4.1.2]

#### Tents

1. Tents shall be erected and located in accordance with NFPA 101: Section 11.11.
2. Tents shall meet the flame propagation performance criteria contained within NFPA 701, *Standard Methods of Fire Tests for Flame Propagation of Textiles and Films*. [NFPA 101: 11.11.2.1]
3. All required means of egress routes must be constantly maintained throughout from any point of origin within any tent, to include the exit discharge to the public way. [NFPA 101: 20.2.5, 38.2.5, 7.5.1.1, 7.1.10.1]
4. Means of egress shall be illuminated and provided with emergency lighting in compliance with NFPA 101:, Section 20.2.9
5. A minimum spacing of not less than 10 feet must be provided between adjacent tents and/or buildings. [NFPA 101: 11.11.3.2 & 11.11.3.5]
6. Tents shall be cleared of all flammable or combustible material or vegetation that is not used for necessary support equipment. [NFPA 101: 11.11.4.1]
7. Only listed and labeled fuel fired heating devices and/or electric heating devices shall be used. [NFPA 101: 11.11.6.1.1 & 11.11.6.2.1]
8. Heaters shall be connected to electricity by an electric cable that is suitable for outside use and is of sufficient use and is of sufficient size to handle the electrical load. [NFPA 101: 11.11.6.2.3]
9. A 2A10BC Portable fire extinguishing equipment shall be furnished, maintained, and placed not more than 75 feet travel distance to reach an extinguisher at any one point within a tent. [NFPA 101: 11.11.5 & NFPA 10] If a fuel fired heater is used, a 2A10BC fire extinguisher must be located not exceeding a 50 Ft. travel distance to reach an extinguisher at any one point within a tent. [NFPA 101: 11.11.6.1.2]
10. The maximum number of people allowed to occupy a room, space, or building (Occupant Load). Occupant load for exterior outside tents used for triage must not be less than 100 Ft<sup>2</sup> per person. [NFPA 101: Table 7.3.1.2]
11. Occupant load for exterior outside tents used to render services to patients for a time duration equaling or exceeding 24 hours.

Healthcare Use	Ft <sup>2</sup> per person
Inpatient treatment departments	240
Sleeping Departments	120

12. Smoking shall be prohibited within and in the near vicinity of any tent that is erected and have plainly visible signs posted that read as follows: "NO SMOKING". [NFPA 101: 11.11.4.2.1 & 11.11.4.2.2]

## COVID-19 FACILITY REQUIREMENTS Temporary Structures

13. Staff shall have the means to contacting first responders (fire department, police department) in the event of a disaster [NFPA 101: 21.7.2.2]
14. Nonflammable medical gas associated with patient care shall not exceed a quantity of 12, size E cylinders (300 Cu. Ft.) and the floor area shall not exceed 22,500 Ft<sup>2</sup>. The container shall be properly secured, such as a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an "operational supply" and not storage. Storage of medical gas cylinders or containers shall be stored outside the tent [NFPA 99: 11.3]

### Mobile Units (Trailer)

1. The maximum number of people allowed to occupy a room, space, or building (Occupant Load). Occupant load for any mobile unit used for triage must not be less than 100 Ft<sup>2</sup> per person. [NFPA 101: Table 7.3.1.2]
2. Mobile units shall be located not less than 10 feet from any building and/or tent, in compliance with [NFPA 101: 4.6.1.2]
3. Means of egress shall be illuminated and provided with emergency lighting in compliance with NFPA 101:, Section 20.2.9
4. All required means of egress routes must be constantly maintained throughout from any point of origin within the mobile unit, to include the exit discharge to the public way. [NFPA 101: 20.2.5, 38.2.5, 7.5.1.1, 7.1.10.1]
5. A 2A10BC Portable fire extinguishing equipment shall be furnished, maintained, and placed not more than 75 feet travel distance to reach an extinguisher at any one point within a mobile unit. [NFPA 101: 11.11.5 & NFPA 10]
6. Nonflammable medical gas associated with patient care shall not exceed a quantity of 12, size E cylinders (300 Cu. Ft.) and the floor area shall not exceed 22,500 Ft<sup>2</sup>. The container shall be properly secured, such as a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an "operational supply" and not storage. Storage of medical gas cylinders or containers shall be stored outside the mobile unit [NFPA 99: 11.3]
7. Staff shall have the means to contacting first responders (fire department, police department) in the event of a disaster. [NFPA 101: 21.7.2.2]

## Hospital Facilities

### Means of Egress

1. All required means of egress routes must be constantly maintained throughout from any point of origin within the facility, to include the exit discharge to the public way. [NFPA 101: 19.2.5.1, 19.2.1, 1, 7.5.1.1, 7.1.10.1]
2. Corridor widths must not be reduced to less than a minimum clear width of 8 feet (96 inches). [NFPA 101: 18.2.3.4]

### Occupant Load

1. The maximum number of people allowed to occupy a room, space, or building (Occupant Load). Occupant load shall be in accordance with NFPA 101, Table 7.3.1.2

Healthcare Use	Ft <sup>2</sup> per person
Inpatient treatment departments	240
Sleeping Departments	120



STATE OF TENNESSEE  
**EXECUTIVE ORDER**  
BY THE GOVERNOR

No. 14

**AN ORDER SUSPENDING PROVISIONS OF CERTAIN STATUTES AND RULES IN ORDER TO FACILITATE THE TREATMENT AND CONTAINMENT OF COVID-19**

**WHEREAS**, Coronavirus Disease 2019 (COVID-19) is a respiratory disease caused by the SARS-CoV-2 virus that can result in mild or severe symptoms, including fever, cough, and shortness of breath, and can lead to serious illness or death, particularly in the case of older adults and persons with serious chronic medical conditions; and

**WHEREAS**, COVID-19 is frequently spread through close contact between persons and respiratory transmission; and

**WHEREAS**, in late 2019, a significant outbreak of COVID-19 was identified in China, and this disease has since spread to many other countries; and

**WHEREAS**, to date, according to the Centers for Disease Control and Prevention (CDC), there have been 938 cases of COVID-19 identified in the United States, which have resulted in 29 deaths; and

**WHEREAS**, on January 16, 2020, the Tennessee Department of Health activated the State Health Operations Center (SHOC), and on January 21, 2020, following CDC guidance, the Department designated COVID-19 as a reportable disease in Tennessee; and

**WHEREAS**, on March 4, 2020, I announced the formation of a Coronavirus Task Force to enhance Tennessee’s coordinated efforts to prevent, identify, and treat potential cases of COVID-19, and that task force convened its first meeting a few days later; and

**WHEREAS**, on March 4, 2020, the first case of COVID-19 in the State of Tennessee was identified, and several additional confirmed or presumptively positive cases of COVID-19 have since been identified in Tennessee; and

**WHEREAS**, on March 11, 2020, the World Health Organization declared the outbreak a global pandemic; and

**WHEREAS**, on January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency to aid the nation's healthcare community in responding to COVID-19; and

**WHEREAS**, several states, including Kentucky, Florida, North Carolina, Colorado, Connecticut, New Jersey, New York, and others, have declared states of emergency to facilitate their responses to COVID-19; and

**WHEREAS**, the spread and identification of additional cases of COVID-19 in Tennessee is likely to continue, and therefore, taking proactive steps to prevent a substantial risk to public health and safety is paramount; and

**WHEREAS**, public and private health care, emergency, and other entities are engaged in efforts throughout the state to treat and prevent the additional spread of COVID-19, and the provisions of this Order are necessary to maximize those efforts to protect the health and safety of Tennesseans; and

**WHEREAS**, Tennessee Code Annotated, Section 58-2-107(c)(1), provides that during a state of emergency, the Governor is authorized to "[s]uspend any law, order, rule or regulation prescribing the procedures for conduct of state business or the orders or rules or regulations of any state agency, if strict compliance with any such law, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the emergency;" and

**WHEREAS**, pursuant to this authority and the general emergency management powers of the Governor under law, the temporary suspension of selected state laws and rules is necessary to facilitate the response to the current public health situation.

**NOW THEREFORE**, I, Bill Lee, Governor of the State of Tennessee, by virtue of the power and authority vested in me by the Tennessee Constitution and other applicable law, do hereby declare a state of emergency exists to facilitate the response to COVID-19 and order the following:

1. The Commissioner of Health or her designee, in conjunction with the Director of the Tennessee Emergency Management Agency (TEMA) or his designee, shall implement the Tennessee Emergency Management Plan (TEMP) and all applicable annexes to coordinate the State's response to COVID-19.
2. The relevant provisions of Tennessee Code Annotated, Titles 63 and 68, and related rules are hereby suspended to the extent necessary to give the Commissioner of Health the discretion to allow a health care professional who is licensed in another state, and who would otherwise be subject to licensing requirements under Title 63 or Title 68, to engage in the practice of such individual's profession in Tennessee,

if such individual is a health care professional who is assisting in the medical response to COVID-19.

3. The provisions of Tennessee Code Annotated, Section 63-10-207(a) and (c), are hereby suspended to allow a pharmacist to dispense an extra 30-day supply of maintenance prescriptions without proper authorization to persons as is necessary to respond to and prevent the spread of COVID-19 in Tennessee, subject to all other provisions of Tennessee Code Annotated, Sections 63-10-207 and 63-1-164.
4. The provisions of Tennessee Code Annotated, Section 68-11-201(20), are hereby suspended to the extent necessary to allow health care professionals who would otherwise be subject to licensing requirements to provide localized treatment of patients in temporary residences.
5. The provisions of Tenn. Comp. R. & Regs. 1200-06-03-.16 are suspended to allow testing for COVID-19 at alternate testing sites without prior approval by the Medical Laboratory Board; provided, that laboratories shall notify the Medical Laboratory Board of any such alternate testing sites.
6. The provisions of Tennessee Code Annotated, Section 68-11-202(c)(1)-(8), are hereby suspended to allow for the construction of temporary structures, the plans for which would otherwise be subject to review for new construction, additions, or substantial alterations, as directed by the Commissioner of Health and the Director of TEMA in response to COVID-19; provided, that there shall be inspections of such structures to ensure safety, as necessary.
7. In accordance with Tennessee Code Annotated, Section 47-18-5103, it is hereby declared that in Tennessee an abnormal economic disruption exists, and therefore, persons are prohibited from charging any other person a price for medical supplies or emergency supplies, as listed in Tennessee Code Annotated, Section 47-18-5103(a)(1)(C) and (D), that is grossly in excess of the price generally charged for the same or similar goods or services in the usual course of business. Paragraph 7 of this Order shall remain in effect until 12:01 a.m., Central Daylight Time, on March 27, 2020.
8. The provisions of Tennessee Code Annotated, Section 55-4-401, through Tennessee Code Annotated, Section 55-4-413, Tennessee Code Annotated, Section 55-7-201, through Tennessee Code Annotated, Section 55-7-209, and Tenn. Comp. R. & Regs. 1680-07-01-.01 through Tenn. Comp. R. & Regs. 1680-07-01-.25 that set forth maximum height, length, and width limitations are hereby suspended in the case of vehicles participating in the response to COVID-19, subject to the following conditions:
  - a. A vehicle must be transporting emergency supplies, equipment, or mobile structures to affected areas.

- b. A vehicle shall be permitted only to travel on (1) Interstate Highways; (2) highways on the National Highway System; and (3) other state-maintained roads as may be required to obtain access to needed services off of the aforementioned highways, without any restrictions on their time of movement except as may otherwise be provided in this Order.
  - c. A vehicle may transport a divisible or non-divisible load up to a maximum gross vehicle weight of 95,000 pounds and a maximum axle weight of 20,000 pounds, except on any bridge or overpass with a lower posted weight limit.
  - d. The outer bridge span of any five-axle truck tractor/semi-trailer combination shall be no less than fifty-one feet (51').
  - e. The overall dimensions of a vehicle and load shall not exceed:
    - i. One hundred feet (100') in length;
    - ii. Fourteen feet, four inches (14' 4") in height on the Interstate Highway System, except on Interstate 55, and thirteen feet, six inches (13' 6") in height on Interstate 55 and any other highway on the National Highway System; or
    - iii. Fourteen feet, six inches (14' 6") in width.
  - f. Vehicles that do not exceed ten feet (10') in width may travel seven (7) days per week during daylight or nighttime hours without any time restrictions.
  - g. Any person, firm, company, corporation, or other entity that undertakes the movement of any overweight and/or overdimensional article and/or commodity on the highways of Tennessee shall hold Tennessee and its officers and employees harmless from any claims for damages resulting from the exercise of any of the privileges granted under this Order and, to this end, shall carry liability insurance with an insurer, acceptable to the Tennessee Department of Transportation's Oversize and Overweight Permit Office, in the amount of not less than three hundred thousand dollars (\$300,000) for each claimant and one million dollars (\$1,000,000) per occurrence. The transporter shall carry the certificate of insurance in the vehicle at all times.
  - h. Paragraph 8(c) of this Order shall take effect only upon the issuance of and in accordance with an appropriate declaration by the President of the United States.
9. In accordance with 49 C.F.R. § 390.23, as adopted by Tenn. Comp. R. & Regs. 1340-06-01-.08, there is hereby provided a temporary exception from the federal rules and regulations in 49 C.F.R. Part 395 limiting the hours of service for the

operator of a commercial motor vehicle providing supplies, equipment, personnel, and other provisions to assist persons affected by COVID-19, subject to the following conditions:

- a. Nothing in this Order shall be construed as an exemption from the Commercial Driver's License requirements in 49 C.F.R. § 383, the financial requirements in 49 C.F.R. § 387, or applicable federal size and weight limitations.
  - b. No motor carrier operating under the terms of this Order shall require or allow an ill or fatigued driver to operate a motor vehicle. A driver who notifies a motor carrier that he or she needs immediate rest shall be given at least ten (10) consecutive hours off-duty before the driver is required to return to service.
10. The relevant provisions of Tennessee Code Annotated, Title 71, Chapter 3, Part 5, and related rules are hereby suspended to the extent necessary to give the Commissioner of Human Services the discretion to waive the child care licensure requirements, including requirements concerning capacity, care categories, grouping, license transfers, and drop-in centers, if necessary to respond to the effects of COVID-19.
  11. The Division of TennCare is hereby authorized to create policies or modify existing policies as is necessary to ensure that members of the TennCare and CoverKids programs continue to receive medically necessary services without disruption during this state of emergency.
  12. Pursuant to Tennessee Code Annotated, Section 58-2-107(e)(2), I hereby direct the Tennessee Department of Health and the Tennessee Department of Commerce and Insurance to continue working with health insurance plans operating in the state to identify and remove any burdens to responding to COVID-19 and improve access to treatment options and medically necessary screening and testing for COVID-19.
  13. This Order shall remain in effect until 12:01 a.m., Central Daylight Time, on May 11, 2020, at which time the suspension of any state laws and rules shall cease and be of no further force or effect.

**IN WITNESS WHEREOF**, I have subscribed my signature and caused the Great Seal of the State of Tennessee to be affixed this 12th day of March, 2020.

  
GOVERNOR

ATTEST  
  
SECRETARY OF STATE





### COVID-19 FACILITY REQUIRMENTS Temporary Structures

#### Fire Department Access

1. Fire department access roads must maintain a width of at least 20 feet wide and a vertical clearance that is unobstructed for a height that is at least 13'-6", for the whole distance of the access road. [NFPA 101: 18.2.3.4.1.1 & 18.2.3.4.1.2]

#### Tents

1. Tents shall be erected and located in accordance with NFPA 101: Section 11.11.
2. Tents shall meet the flame propagation performance criteria contained within NFPA 701, *Standard Methods of Fire Tests for Flame Propagation of Textiles and Films*. [NFPA 101: 11.11.2.1]
3. All required means of egress routes must be constantly maintained throughout from any point of origin within any tent, to include the exit discharge to the public way. [NFPA 101: 20.2.5, 38.2.5, 7.5.1.1, 7.1.10.1]
4. Means of egress shall be illuminated and provided with emergency lighting in compliance with NFPA 101:, Section 20.2.9
5. A minimum spacing of not less than 10 feet must be provided between adjacent tents and/or buildings. [NFPA 101: 11.11.3.2 & 11.11.3.5]
6. Tents shall be cleared of all flammable or combustible material or vegetation that is not used for necessary support equipment. [NFPA 101: 11.11.4.1]
7. Only listed and labeled fuel fired heating devices and/or electric heating devices shall be used. [NFPA 101: 11.11.6.1.1 & 11.11.6.2.1]
8. Heaters shall be connected to electricity by an electric cable that is suitable for outside use and is of sufficient use and is of sufficient size to handle the electrical load. [NFPA 101: 11.11.6.2.3]
9. A 2A10BC Portable fire extinguishing equipment shall be furnished, maintained, and placed not more than 75 feet travel distance to reach an extinguisher at any one point within a tent. [NFPA 101: 11.11.5 & NFPA 10] If a fuel fired heater is used, a 2A10BC fire extinguisher must be located not exceeding a 50 Ft. travel distance to reach an extinguisher at any one point within a tent. [NFPA 101: 11.11.6.1.2]
10. The maximum number of people allowed to occupy a room, space, or building (Occupant Load). Occupant load for exterior outside tents used for triage must not be less than 100 Ft<sup>2</sup> per person. [NFPA 101: Table 7.3.1.2]
11. Occupant load for exterior outside tents used to render services to patients for a time duration equaling or exceeding 24 hours.

Healthcare Use	Ft <sup>2</sup> per person
Inpatient treatment departments	240
Sleeping Departments	120

12. Smoking shall be prohibited within and in the near vicinity of any tent that is erected and have plainly visible signs posted that read as follows: "NO SMOKING". [NFPA 101: 11.11.4.2.1 & 11.11.4.2.2]



**COVID-19 FACILITY REQUIRMENTS  
Temporary Structures**

- 13. Staff shall have the means to contacting first responders (fire department, police department) in the event of a disaster. [NFPA 101: 21.7.2.2]
- 14. Nonflammable medical gas associated with patient care shall not exceed a quantity of 12, size E cylinders (300 Cu. Ft.) and the floor area shall not exceed 22,500 Ft<sup>2</sup>. The container shall be properly secured, such as a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an "operational supply" and not storage. Storage of medical gas cylinders or containers shall be stored outside the tent [NFPA 99: 11.3]

**Mobile Units (Trailer)**

- 1. The maximum number of people allowed to occupy a room, space, or building (Occupant Load). Occupant load for any mobile unit used for triage must not be less than 100 Ft<sup>2</sup> per person. [NFPA 101: Table 7.3.1.2]
- 2. Mobile units shall be located not less than 10 feet from any building and/or tent, in compliance with [NFPA 101: 4.6.1.2]
- 3. Means of egress shall be illuminated and provided with emergency lighting in compliance with NFPA 101:, Section 20.2.9
- 4. All required means of egress routes must be constantly maintained throughout from any point of origin within the mobile unit, to include the exit discharge to the public way. [NFPA 101: 20.2.5, 38.2.5, 7.5.1.1, 7.1.10.1]
- 5. A 2A10BC Portable fire extinguishing equipment shall be furnished, maintained, and placed not more than 75 feet travel distance to reach an extinguisher at any one point within a mobile unit. [NFPA 101: 11.11.5 & NFPA 10]
- 6. Nonflammable medical gas associated with patient care shall not exceed a quantity of 12, size E cylinders (300 Cu. Ft.) and the floor area shall not exceed 22,500 Ft<sup>2</sup>. The container shall be properly secured, such as a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an "operational supply" and not storage. Storage of medical gas cylinders or containers shall be stored outside the mobile unit [NFPA 99: 11.3]
- 7. Staff shall have the means to contacting first responders (fire department, police department) in the event of a disaster. [NFPA 101: 21.7.2.2]

**Hospital Facilities**

**Means of Egress**

- 1. All required means of egress routes must be constantly maintained throughout from any point of origin within the facility, to include the exit discharge to the public way. [NFPA 101: 19.2.5.1, 19.2.1, 1, 7.5.1.1, 7.1.10.1]
- 2. Corridor widths must not be reduced to less than a minimum clear width of 8 feet (96 inches). [NFPA 101: 18.2.3.4]

**Occupant Load**

- 1. The maximum number of people allowed to occupy a room, space, or building (Occupant Load). Occupant load shall be in accordance with NFPA 101: Table 7.3.1.2

<b>Healthcare Use</b>	<b>Ft<sup>2</sup> per person</b>
Inpatient treatment departments	240
Sleeping Departments	120



**MEMORANDUM**

**DATE:** March 11, 2020  
**TO:** Long-Term Care Facilities  
**FROM:** Lisa Piercey, MD, MBA, FAAP, Commissioner  
**SUBJECT:** COVID-19 (Novel Coronavirus) Guidance for Long-Term Care Facilities

As you know, older persons or people with underlying medical conditions are at increased risk of severe complications from COVID-19 infection. The Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) have recently issued guidance recommending that nursing facilities screen visitors and staff for symptoms of respiratory infection, international travel to restricted countries, and contact with anyone who has or is suspected to have COVID-19.

Links to these guidance documents are available on-line:

CMS Guidance: <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurvey/certificationgeninfo/policy-and/qso-20-14-nh.pdf>

CDC Guidance: <https://www.cdc.gov/coronavirus/2019-nCoV/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>

These guidelines contain extensive details and recommendations for long-term care facilities (LTCF). Examples of such recommendations include:

- Visitation should be limited to only those who are essential for the resident’s emotional well-being and care (e.g. families of person receiving end-of-life care).
- Restrict non-essential personnel including volunteers and non-essential consultant personnel from entering the building.
- Send letters or emails to families advising them of limitations to visitation, and facilitate use of alternative methods for visitation (e.g., video conferencing) during the next several months.
- Post signs at the entrances to the facility instructing visitors to not enter if they have fever or symptoms of a respiratory infection.
- Screen all healthcare personnel at the beginning of their shift for fever and respiratory symptoms.
- Actively monitor all residents (at least daily) for fever and respiratory symptoms (shortness of breath, new or change in cough, and sore throat).

An extensive amount of information regarding COVID-19, including advice for medical providers, patients, and the general public is available on the websites of the Tennessee Departments of Health (<https://www.tn.gov/health/cedep/ncov.html>) and CDC (<https://www.cdc.gov/coronavirus/2019-nCoV/>). In addition, for general questions the public can contact our hotline between 10am and 10pm (877-857-2945). Questions from medical institutions and medical providers can be directed to (615) 741-7247.

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-12-All

**DATE:** March 4, 2020  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Quality, Safety & Oversight Group  
**SUBJECT:** Suspension of Survey Activities

Memorandum Summary

- *CMS is committed* to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of the 2019 Novel Coronavirus (COVID-19).
- The Centers for Medicare & Medicaid Services (CMS) CMS is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of the COVID-19 and other respiratory illnesses.

Background

CMS is committed to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19 and other respiratory illness. Specifically, CMS is suspending non-emergency inspections across the country, allowing inspectors to turn their focus on the most serious health and safety threats like infectious diseases and abuse. This shift in approach will also allow inspectors to focus on addressing the spread of the coronavirus disease 2019 (COVID-19). CMS is issuing this memorandum to State Survey Agencies to provide important guidelines for the inspection process in situations in which a COVID-19 is suspected.

Discussion

Effective immediately, survey activity is limited to the following (in Priority Order):

- All immediate jeopardy complaints (cases that represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death or harm) and allegations of abuse and neglect;
- Complaints alleging infection control concerns; including facilities with potential COVID-19 or other respiratory illnesses;

- Statutorily required recertification surveys (Nursing Home, Home Health, Hospice, and ICF/IID facilities);
- Any re-visits necessary to resolve current enforcement actions;
- Initial certifications;
- Surveys of facilities/hospitals that have a history of infection control deficiencies at the immediate jeopardy level in the last three years;
- Surveys of facilities/hospitals/dialysis centers that have a history of infection control deficiencies at lower levels than immediate jeopardy.

Due to the dynamic nature of this situation, we will be posting updated FAQs in real-time at the following website: <https://www.cms.gov/medicare/quality-safety-oversight-general-information/coronavirus>

For survey of facilities with Complaints alleging infection control concerns, including facilities with potential COVID-19 or other respiratory illness, please refer to the attached (Attachment A- Survey Planning in Facilities with Active or Suspected Cases of COVID-19 Cases; Attachment B- Infection Prevention, Control & Immunizations).

**Contact:** Questions about this document should be addressed to [OSOG\\_EmergencyPrep@cms.hhs.gov](mailto:OSOG_EmergencyPrep@cms.hhs.gov).

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/

David R. Wright

Attachment A- Survey Planning in Facilities with Active or Suspected Cases of COVID-19 Cases

Attachment B- Infection Prevention, Control & Immunizations

cc: Survey and Operations Group Management

## Attachment A- Survey Planning in Facilities with Active or Suspected Cases of COVID-19 Cases

### I. Protocols for Coordination and Investigation of Facilities with Actual or Suspected COVID-19 Cases

When a COVID-19 confirmed case or presumptive positive case (e.g., positive local test but pending confirmatory test), is identified in a Medicare/Medicaid certified provider or supplier, State Survey Agencies and Accrediting Organizations (AO) are requested to do the following:

- Notify the appropriate CMS Regional Office (if they are not already aware) of the facility and date of patient/resident COVID-19 or presumptive respiratory illness or confirmed status;
- Coordinate on initiating any Federal complaint or recertification survey of the impacted facility until CDC (and any other relevant Federal/State/Local response agencies) have cleared the facility for survey. The CMS Regional Office will then authorize a survey, if necessary;
- Ensure surveyors have all necessary Personal Protective Equipment (PPE) appropriate to allow a survey of the facility; Refer to CDC Infection Control resources for the most up to date guidance.
- Suspend any Federal enforcement action for any deficiencies identified until reviewed and approved by the CMS Regional Office to ensure consistent and appropriate action.

These protocols will be updated as circumstances warrant. We are asking Accrediting Organizations to copy their CMS AO liaison on any communications with the CMS Regional Office.

### II. Focused Surveying – Prioritizing Threats

In all cases, concerns of **Immediate Jeopardy** (IJ) (cases that represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death or harm) and cases of abuse and neglect allegations from complaints will continue to receive high priority for survey. Non-emergency surveys will be suspended.

### III. Survey Planning in Facilities with Active or Suspected Cases of COVID-19 Infection

#### **Introduction: Under What Circumstances Will CMS Authorize an On-site Survey/Investigation of a Facility With Persons who are Known or Suspected of Being COVID-19 Positive**

When a COVID-19 confirmed case or presumptive positive case (e.g., positive local test but pending confirmatory test), is identified in a Medicare/Medicaid certified provider or supplier,

State Survey Agencies and Accrediting Organizations must notify the appropriate CMS Regional location (if they are not already aware) of the facility and date of patient/resident COVID-19 presumptive or confirmed status.

Before initiating any Federal complaint or recertification survey of the impacted facility, CMS will coordinate with the CDC (and any other relevant Federal/State/Local response agencies) to approve the facility for survey.

The CMS Regional locations will authorize an on-site survey if reported conditions at the facility are triaged at immediate jeopardy. Immediate jeopardy means there are conditions at the facility that are causing or are likely to cause one or more recipients of care to suffer serious injury, harm, impairment or death. CMS Regional locations will also authorize on-site surveys where the complaint or facility reported incident involves infection control concerns in the facility.

If conditions at such facilities do not rise to the immediate jeopardy level, then desk audits will be performed, and on-site investigations may be authorized once all active or suspected cases of COVID-19 have been cleared from the facility.

#### **I. Before Survey Entry**

Determine survey team composition for minimal but optimal number of surveyors required to efficiently and effectively conduct the onsite observations required. Generally, one to two surveyors for an abbreviated complaint survey focusing on the COVID-19 infection control and/or quality of care issues would be sufficient. Do not include any surveyors who are currently ill or have underlying health conditions that may make them particularly vulnerable to COVID-19.

##### **A. Personal Protective Equipment Considerations**

Ensure survey team members have needed personal protective equipment (PPE) that may be required onsite to observe resident care in close quarters. If the facility has gowns, gloves, face shields or other eye protection that may be used by surveyors, such PPE may be used onsite by surveyors. However, if observation of care provided to symptomatic patients/residents who are confirmed or presumed to be COVID-19 positive is anticipated, then survey agencies and accrediting organizations should refer to the CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare

Settings: <https://www.cdc.gov/coronavirus/2019-nCoV/infection-control/control-recommendations.html>.

This guidance indicates, “Respirator use must be in the context of a complete respiratory protection program in accordance with Occupational Safety and Health Administration (OSHA) Respiratory Protection standard 29 CFR 1910.134). Staff should be medically cleared and fit-tested if using respirators with tight-fitting face-pieces (e.g., a NIOSH-certified disposable N95) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use...” More information on the use of respirators may be found here: [https://www.osha.gov/SLC/tools/respiratory/respirator\\_basics.html](https://www.osha.gov/SLC/tools/respiratory/respirator_basics.html)

### B. Offsite Planning Considerations

Conduct offsite planning based on available information from: (1) facility-reported information; (2) CDC information and guidance from its onsite visit before the SA/CMS investigation; (3) available hospital information regarding patients transferred to the hospital; and/or (4) complaint allegations. Determine and prioritize key observations that should be conducted. Compile a preliminary list of the likely interviews with various facility staff and the types of records, policies or other documents that may be needed. This may be revised after onsite observations and interviews, which may lead to additional areas of investigation.

## II. Onsite Survey Activities

Upon entry, notify the facility administrator of the limited nature of the planned survey. Coordinate with the facility staff a plan and timeline for conducting the needed observations. Plan to conduct as many observations on the entry day. If by the end of the first day, the surveyors were not able to completed necessary observations, coordinate with the facility when the observations may be completed by the next day. Unless there are extenuating circumstances, plan to complete all onsite observations and corresponding interviews within two days. When possible during observations, if symptomatic patients/residents are able to tolerate wearing face masks, this will reduce the need for surveyors to wear respirator masks.

Coordinate with the facility on how to gather medical record information, with the goal to conduct as much record review offsite as possible. If the facility has an electronic health record (EHR) system that may be accessed remotely, request remote access to the EHR to review needed records for a limited period of time. If this is not an option, discuss with the facility the best options to get needed medical record information, such as fax, secure website, encrypted email, etc.

Adhere to Standard, Contact and Airborne Precautions and refer to the CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings.

During onsite observation and investigation, focus on concerns with:

- Improper transmission precautions procedures
- Lack of staff knowledge of transmission precautions
- Improper staff use of PPE and/or inadequate hand hygiene
- High-risk, significant environmental cleaning issues
- Ineffective and/or improper laundering of linens
- Possible IC surveillance program issues - also consider how influenza & pneumococcal programs are managed

Conduct concurrent interviews of staff with observations during or directly after observations as appropriate. Conduct needed interviews with patients/residents onsite, as these may be difficult to obtain offsite. Patients may be discharged. Residents may have a difficult time responding to questions by telephone. While onsite, if there are periods of time when no observations can be made, attempt to conduct other needed interviews and review medical records.

For nursing home investigations, use the LTC investigative protocols for infection control (IC) and the environment:

### **III. Complete Survey Offsite**

Except for interviews that should be conducted concurrently with observations, conduct other interviews offsite with staff by telephone. If any patient/resident interviews could not be conducted while onsite, then attempt to conduct those by telephone.

After coordinating with the facility and determining what medical record review may be conducted offsite, complete as much of the record review offsite as possible. Request facility policies and procedures for review offsite.

In addition, consider investigating Governing Body and Quality Assurance Performance Improvement requirements that may relate to infection control or care issues offsite through telephone interviews and additional record review.

After completing all investigative procedures, determine compliance status and conduct any survey exit discussion with the facility by telephone. Draft the CMS-2567 offsite.

### **III: Enforcement Activities**

Surveys resulting in deficiencies will have the imposition of some type of enforcement action ranging from request for corrective action plans to termination depending on the circumstances surrounding deficiencies.

## Infection Prevention, Control & Immunizations

**Infection Control:** *This facility task must be used to investigate compliance at F880, F881, and F883. For the purpose of this task, "staff" includes employees, consultants, contractors, volunteers, and others who provide care and services to residents on behalf of the facility. The Infection Prevention and Control Program (IPCP) program must be facility-wide and include all departments and contracted services. If a specific care area concern is identified, it should be evaluated under the specific care area, such as for pressure ulcers, respiratory care, catheter care, and medication pass observations which include central lines, peripheral IV's, and oral/IM respiratory medications.*

### Coordination:

- One surveyor coordinates the facility task to review for:
  - The overall Infection Prevention and Control Program (IPCP);
  - The annual review of the IPCP policies and practices;
  - The review of the surveillance and antibiotic stewardship programs; and
  - Tracking influenza/pneumococcal immunization of residents.
- Team assignments must be made to include the review of:
  - Laundry services;
  - A resident on transmission-based precautions, if any;
  - Five sampled residents for influenza/pneumococcal immunizations; and
  - Other care-specific observations if concerns are identified.
- Every surveyor assesses IPCP compliance throughout the survey and communicates any concerns to the team.

### Hand Hygiene:

- Staff implement standard precautions (e.g., hand hygiene and the appropriate use of personal protective equipment (PPE)).
- Appropriate hand hygiene practices are followed.
- Alcohol-based hand rub (ABHR) is readily accessible and placed in appropriate locations. These may include:
  - Entrances to resident rooms;
  - At the bedside (as appropriate for resident population);
  - In individual pocket-sized containers by healthcare personnel;
  - Staff work stations; and
  - Other convenient locations.
- Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected *C. difficile* infection (CDI) or norovirus during an outbreak, or if endemic rates of CDI are high. ABHR is not appropriate to use under these circumstances.
- Staff perform hand hygiene (even if gloves are used) in the following situations:
  - Before and after contact with the resident;

## Infection Prevention, Control & Immunizations

- After contact with blood, body fluids, or visibly contaminated surfaces or other objects and surfaces in the resident's environment;
  - After removing personal protective equipment (e.g., gloves, gown, facemask); and
  - Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, and/or dressing care).
- When being assisted by staff, resident hand hygiene is performed after toileting and before meals.
- Interview appropriate staff to determine if hand hygiene supplies are readily available and who they contact for replacement supplies.
- Soap, water, and a sink are readily accessible in appropriate locations including, but not limited to, resident care areas, food and medication preparation areas.

**1. Did staff implement appropriate hand hygiene?**  Yes  No **F880**

### Personal Protective Equipment (PPE):

- Determine if staff appropriately use and discard PPE including, but not limited to, the following:
- Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
  - Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin;
  - Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care;
  - A gown is worn for direct resident contact if the resident has uncontained secretions or excretions;
  - A facemask is worn if contact (i.e., within 3 feet) with a resident with new acute cough or symptoms of a respiratory infection (e.g., influenza-like illness);
  - Appropriate mouth, nose, and eye protection (e.g., facemasks, face shield) is worn for performing aerosol-generating and/or procedures that are likely to generate splashes or sprays of blood or body fluids;
  - PPE is appropriately discarded after resident care, prior to leaving room, followed by hand hygiene; and
  - Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (i.e., nursing units, therapy rooms).
- Interview appropriate staff to determine if PPE supplies are readily available and who they contact for replacement supplies.

**2. Did staff implement appropriate use of PPE?**  Yes  No **F880**

### Transmission-Based Precautions:

- Determine if appropriate transmission-based precautions are implemented, including but not limited to:
- PPE use by staff (i.e., don gloves and gowns before contact with the resident and/or his/her environment while on contact precautions; don facemask within three feet of a resident on droplet precautions; don a fit-tested N95 or higher level respirator prior to room entry of a resident on airborne precautions;

## Infection Prevention, Control & Immunizations

- Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant prior to use on another resident.
  - The least restrictive TBP possible under the circumstances;
  - Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare use at least daily and when visibly soiled.
- Interview appropriate staff to determine if they are aware of processes/protocols for transmission-based precautions and how staff is monitored for compliance.
- If concerns are identified, expand the sample to include more residents with transmission-based precautions.

**3. Did the staff implement appropriate transmission-based precautions?**     Yes     No **F880**     NA

### Laundry Services:

- Determine whether staff handle, store, and transport linens appropriately including, but not limited to:
- Using standard precautions (i.e., gloves) and minimal agitation for contaminated linen;
  - Holding contaminated linen and laundry bags away from his/her clothing/body during transport;
  - Bagging/containing contaminated linen where collected, and sorted/rinsed only in the contaminated laundry area (double bagging of linen is only recommended if outside of the bag is visibly contaminated or is observed to be wet on the outside of the bag);
  - Transporting contaminated and clean linens in separate carts; if this is not possible, the contaminated linen cart should be thoroughly cleaned and disinfected per facility protocol before being used to move clean linens. Clean linens are transported by methods that ensure cleanliness, e.g., protect from dust and soil;
  - Ensuring mattresses, pillows, bedding, and linens are maintained in good condition and are clean (Refer to F584); and
  - If a laundry chute is in use, laundry bags are closed with no loose items.
- Laundry Rooms – Determine whether staff:
- Maintain/use washing machines/dryers according to the manufacturer's instructions for use;
  - If concerns, request evidence of maintenance log/record; and
  - Use detergents, rinse aids/additives, and follow laundering directions according to the manufacturer's instructions for use.

**4. Did the facility store, handle, transport, and process linens properly?**     Yes     No **F880**

## Infection Prevention, Control & Immunizations

### Policy and Procedure:

- The facility established a facility-wide IPCP including written IPCP standards, policies, and procedures that are current and based on national standards.
- The policies and procedures are reviewed at least annually.
- Concerns must be corroborated as applicable including the review of pertinent policies/procedures as necessary.

5. Did the facility develop and implement an overall IPCP including policies and procedures that are reviewed annually?

- Yes  No F880

### Infection Surveillance:

- The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring and/or reporting of infections.
- The plan includes early detection, management of a potentially infectious, symptomatic resident and the implementation of appropriate transmission-based precautions.
- The plan uses evidence-based surveillance criteria (e.g., CDC NHSN Long-Term Care or revised McGeer Criteria) to define infections and the use of a data collection tool.
- The plan includes ongoing analysis of surveillance data and review of data and documentation of follow-up activity in response.
- The facility has a process for communicating the diagnosis, antibiotic use, if any, and laboratory test results when transferring a resident to an acute care hospital or other healthcare provider; and obtaining pertinent notes such as discharge summary, lab results, current diagnoses, and infection or multidrug-resistant organism colonization status when residents are transferred back from acute care hospitals.
- The facility has a current list of reportable communicable diseases.
- Staff can identify to whom and when communicable diseases, healthcare-associated infections (as appropriate), and potential outbreaks must be reported.
- Prohibiting employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit disease.
- Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.

6. Did the facility provide appropriate infection surveillance?  Yes  No F880

### Antibiotic Stewardship Program:

- Determine whether the facility has an antibiotic stewardship program that includes:

## Infection Prevention, Control & Immunizations

- Written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage, and duration of use of antibiotics;
- Protocols to review clinical signs and symptoms and laboratory reports to determine if the antibiotic is indicated or if adjustments to therapy should be made and identify what infection assessment tools or management algorithms are used for one or more infections (e.g., SBAR tool for urinary tract infection (UTI) assessment, Loeb minimum criteria for initiation of antibiotics);
- A process for a periodic review of antibiotic use by prescribing practitioners: for example, review of laboratory and medication orders, progress notes and medication administration records to determine whether or not an infection or communicable disease has been documented and whether an appropriate antibiotic has been prescribed for the recommended length of time. Determine whether the antibiotic use monitoring system is reviewed when the resident is new to the facility, when a prior resident returns or is transferred from a hospital or other facility, during each monthly drug regimen review when the resident has been prescribed or is taking an antibiotic, or any antibiotic drug regimen review as requested by the QAA committee;
- Protocols to optimize the treatment of infections by ensuring that residents who require antibiotics are prescribed the appropriate antibiotic;
- A system for the provision of feedback reports on antibiotic use, antibiotic resistance patterns based on laboratory data, and prescribing practices for the prescribing practitioner.

### 7. Did the facility conduct ongoing review for antibiotic stewardship? Yes No F881

#### Influenza and Pneumococcal Immunizations:

- Select five residents in the sample to review for the provision of influenza/pneumococcal immunizations.
- Document the names of residents selected for review.
- Give precedence in selection to those residents whom the survey team has selected as sampled residents.
- Review the records of the five residents sampled for documentation of:
  - Screening and eligibility to receive the vaccine;
  - The provision of education related to the influenza or pneumococcal immunizations (such as the benefits and potential side effects);
  - The administration of pneumococcal and influenza vaccine, in accordance with national recommendations. Facilities must follow the CDC and ACIP recommendations for vaccines; and
  - Allowing a resident or representative to refuse either the influenza and/or pneumococcal vaccine. If not provided, documentation as to why the vaccine was not provided.
- For surveys occurring during influenza season, unavailability of the influenza vaccine can be a valid reason why a facility has not implemented the influenza vaccine program, especially during the early weeks of the influenza season. Ask the facility to demonstrate that:
  - The vaccine has been ordered and the facility received a confirmation of the order indicating that the vaccine has been shipped or that the product is not available but will be shipped when the supply is available; and
  - Plans are developed on how and when the vaccines are to be administered.

## Infection Prevention, Control & Immunizations

As necessary, determine if the facility developed influenza and pneumococcal vaccine policies and procedures, including the identification and tracking/monitoring of all facility residents' vaccination status.

8. Did the facility provide influenza and/or pneumococcal immunizations as required or appropriate?  Yes  No F883

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850



EXHIBIT  
tabbies  
Attachment E

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-13-Hospitals

**DATE:** March 4, 2020  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Quality, Safety & Oversight Group  
**SUBJECT:** Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge

Memorandum Summary

- **CMS is committed** to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.
- **Coordination with the Centers for Disease Control (CDC) and local public health departments** - We encourage all hospitals to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>).
- **Hospital Guidance and Actions** - CMS regulations and guidance support hospitals taking appropriate action to address potential and confirmed COVID cases and mitigate transmission including screening, discharge and transfers from the hospital, and visitation.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to the protection of patients and residents of healthcare facilities from the spread of infectious disease. This memorandum responds to questions we have received and provides important guidance for hospitals and critical access hospitals (CAH's) in addressing the COVID-19 outbreak and minimizing transmission to other individuals. Specifically, we address FAQs related to optimizing patient placement, with the goal of addressing the needs of the individual patient while protecting other patients and healthcare workers.

Guidance

Hospitals should monitor the CDC website (<https://www.cdc.gov/coronavirus/2019-ncov/index.html>) for up to date information and resources. They should contact their local health department if they have questions or suspect a patient or healthcare provider has COVID-19. Hospitals should have plans for monitoring healthcare personnel with exposure to patients with known or suspected COVID-19. Additional information about monitoring healthcare personnel

is available here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>

### **Guidance for Addressing Patient Triage and Placement of Patients with known or suspected COVID-19**

#### **Which patients are at risk for severe disease for COVID-19?**

Based upon CDC data, older adults and those with underlying chronic medical conditions or immunocompromised state may be most at risk for severe outcomes. This should be considered in the decision to monitor the patient as an outpatient or inpatient.

#### **How should facilities screen visitors and patients for COVID-19?**

Hospitals should identify visitors and patients at risk for having COVID-19 infection before or immediately upon arrival to the healthcare facility. They should ask patients about the following:

1. Fever or symptoms of a respiratory infection, such as a cough and sore throat.
2. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>
3. Contact with someone with known or suspected COVID-19.

For patients, implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient's nose and mouth if that has not already been done) and isolate the patient in an examination room with the door closed. If the patient cannot be immediately moved to an examination room, ensure they are not allowed to wait among other patients seeking care. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. In some settings, medically-stable patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.

Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a person under investigation for COVID-19. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC [COVID-19 website](#).

Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, facemasks, and tissues at healthcare facility entrances, waiting rooms, patient check-ins, etc.

#### **How should facilities monitor or restrict health care facility staff?**

The same screening performed for visitors should be performed for hospital staff.

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:

- Immediately stop work, put on a facemask, and self-isolate at home;
  - Inform the hospital's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and
  - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>).

Hospitals should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html>).

**What are recommended infection prevention and control practices, including considerations for patient placement, when evaluating and care for a patients with known or suspected COVID-19?**

Recommendations for patient placement and other detailed infection prevention and control recommendations regarding hand hygiene, Transmission-Based Precautions, environmental cleaning and disinfection, managing visitors, and monitoring and managing healthcare personnel are available in the [CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 \(COVID-19\) or Persons under Investigation for COVID-19 in Healthcare Settings](#).

**Do all patients with known or suspected COVID-19 infection require hospitalization?**

Patients may not require hospitalization and can be managed at home if they are able to comply with monitoring requests. More information is available here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html>

**Are there specific considerations for patients requiring diagnostic or therapeutic interventions?**

Patients with known or suspected COVID-19 should continue to receive the intervention appropriate for the severity of their illness and overall clinical condition. Because some procedures create high risks for transmission (e.g., intubation) additional precautions include: 1) HCP should wear all recommended PPE, 2) the number of HCP present should be limited to essential personnel, and 3) the room should be cleaned and disinfected in accordance with environmental infection control guidelines.

Additional information about performing aerosol-generating procedures is available here: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

**When is it safe to discontinue Transmission-based Precautions for hospitalized patients with COVID-19?**

The decision to discontinue [Transmission-Based Precautions](#) for hospitalized patients with COVID-19 should be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. This decision should consider disease severity, illness signs and symptoms, and results of laboratory testing for COVID-19 in respiratory specimens

More detailed information about criteria to discontinue Transmission-Based Precautions are available here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>

**Can hospitals restrict visitation of patients?**

Medicare regulations require a hospital to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. CMS sub-regulatory guidance identifies infection control concern as an example of when clinical restrictions may be warranted. Patients must be informed of his/her visitation rights and the clinical restrictions or limitations on visitation.

The development of such policies and procedures require hospitals to focus efforts on preventing and controlling infections, not just between patients and personnel, but also between individuals across the entire hospital setting (for example, among patients, staff, and visitors) as well as between the hospital and other healthcare institutions and settings and between patients and the healthcare environment. Hospitals should work with their local, State, and Federal public health agencies to develop appropriate preparedness and response strategies for communicable disease threats.

**What are the considerations for discharge to a subsequent care location for patients with COVID-19?**

The decision to discharge a patient from the hospital should be made based on the clinical condition of the patient. If Transmission-Based Precautions must be continued in the subsequent setting, the receiving facility must be able to implement all recommended infection prevention and control recommendations.

Although COVID-19 patients with mild symptoms may be managed at home, the decision to discharge to home should consider the patient's ability to adhere to isolation recommendations, as well as the potential risk of secondary transmission to household members with immunocompromising conditions. More information is available here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html>

**What are the implications of the Medicare Hospital Discharge Planning Regulations for Patients with COVID-19?**

Medicare's Discharge Planning Regulations (which were updated in November 2019) requires that hospital assess the patient's needs for post-hospital services, and the availability of such services. When a patient is discharged, all necessary medical information (including communicable diseases) must be provided to any post-acute service provider. For COVID-19 patients, this must be communicated to the receiving service provider prior to the discharge/transfer and to the healthcare transport personnel.

**Can hospitals restrict visitation of patients?**

Medicare regulations require a hospital to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. CMS sub-regulatory guidance identifies infection control

concern as an example of when clinical restrictions may be warranted. Patients must be informed of his/her visitation rights and the clinical restrictions or limitations on visitation.

The development of such policies and procedures require hospitals to focus efforts on preventing and controlling infections, not just between patients and personnel, but also between individuals across the entire hospital setting (for example, among patients, staff, and visitors) as well as between the hospital and other healthcare institutions and settings and between patients and the healthcare environment. Hospitals should work with their local, State, and Federal public health agencies to develop appropriate preparedness and response strategies for communicable disease threats.

#### **Important CDC Resources:**

- CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>
- CDC Updates: <https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html>
- CDC FAQ for COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html>
- CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID19) or Persons Under Investigation for COVID-19 in Healthcare Settings.: [https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control/recommendations.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html](https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control/recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html)

#### **CDC Updates:**

<https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html>

#### **CMS Resources**

CMS has additional guidance which may be beneficial to hospitals related to EMTALA requirements and other topics surrounding the health and safety standards during emergencies. The document Provider Survey and Certification Frequently Asked Questions (FAQs), Declared Public Health Emergency All-Hazards are located at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/All-Hazards-FAQs.pdf>. These FAQs are not limited to situations involving 1135 Waivers, but are all encompassing FAQs related to public health emergencies and survey activities and functions.

**Contact:** Questions about this memorandum should be addressed to [QSOG\\_EmergencyPrep@cms.hhs.gov](mailto:QSOG_EmergencyPrep@cms.hhs.gov). Questions about COVID-19 guidance/screening criteria should be addressed to the State Epidemiologist or other responsible state or local public health officials in your state.

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/

David R. Wright

cc: Survey and Operations Group Management

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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-14-NH

**DATE:** March 4, 2020

**TO:** State Survey Agency Directors

**FROM:** Director  
Quality, Safety & Oversight Group

**SUBJECT:** Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes

**Memorandum Summary**

- ***CMS is committed*** to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.
- **Guidance for Infection Control and Prevention of COVID-19** - CMS is providing additional guidance to nursing homes to help them improve their infection control and prevention practices to prevent the transmission of COVID-19.
- **Coordination with the Centers for Disease Control (CDC) and local public health departments** - We encourage all nursing homes to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-nCoV/healthcare-facilities/index.html>).

**Background**

CMS is responsible for ensuring the health and safety of nursing homes by enforcing the standards required to help each resident attain or maintain their highest level of well-being. In light of the recent spread of COVID-19, we're providing additional guidance to nursing homes to help control and prevent the spread of the virus.

**Guidance**

Facilities should monitor the CDC website for information and resources (links below). They should contact their local health department if they have questions or suspect a resident of a nursing home has COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent monitoring for potential symptoms of respiratory infection as needed throughout the day. Furthermore, we encourage facilities to take advantage of resources that have been made available by CDC and

CMS to train and prepare staff to improve infection control and prevention practices. Lastly, facilities should maintain a person-centered approach to care. This includes communicating effectively with patients, patient representatives and/or their family, and understanding their individual needs and goals of care.

Facilities experiencing an increased number of respiratory illnesses (regardless of suspected etiology) among patients/residents or healthcare personnel should immediately contact their local or state health department for further guidance.

In addition to the overarching regulations and guidance, we're providing the following information (Frequently Asked Questions) about some specific areas related to COVID-19:

### **Guidance for Limiting the Transmission of COVID-19 for Nursing Homes**

#### **How should facilities monitor or limit visitors?**

Facilities should screen visitors for the following:

1. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>
2. Signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat.
3. Has had contact with someone with or under investigation for COVID-19.

If visitors meet the above criteria, facilities may restrict their entry to the facility. Regulations and guidance related to restricting a resident's right to visitors can be found at 42 CFR §483.10(f)(4), and at F-tag 563 of Appendix PP of the State Operations Manual. Specifically, a facility may need to restrict or limit visitation rights for reasonable clinical and safety reasons. This includes, "restrictions placed to prevent community-associated infection or communicable disease transmission to the resident. A resident's risk factors for infection (e.g., immunocompromised condition) or current health state (e.g., end-of-life care) should be considered when restricting visitors. In general, visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) should defer visitation until he or she is no longer potentially infectious (e.g., 24 hours after resolution of fever without antipyretic medication)."

#### **How should facilities monitor or restrict health care facility staff?**

The same screening performed for visitors should be performed for facility staff (numbers 1, 2, and 3 above).

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:
  - Immediately stop work, put on a facemask, and self-isolate at home;
  - Inform the facility's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and
  - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>).

Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>).

**When should nursing homes consider transferring a resident with suspected or confirmed infection with COVID-19 to a hospital?**

Nursing homes with residents suspected of having COVID-19 infection should contact their local health department. Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms or fatality. Initially, symptoms may be mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the patient assuming: 1) the patient does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19. (<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>)

The resident may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, emergency medical services and the receiving facility should be alerted to the resident's diagnosis, and precautions to be taken including placing a facemask on the resident during transfer. If the patient does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially appropriate. Pending transfer or discharge, place a facemask on the patient and isolate him/her in a room with the door closed.

**When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?**

A nursing home can accept a patient diagnosed with COVID-19 and still under Transmission-based Precautions for COVID-19 as long as it can follow CDC guidance for transmission-based precautions. If a nursing home cannot, it must wait until these precautions are discontinued. CDC has released [Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory-confirmed COVID-19](#). Information on the duration of infectivity is limited, and the interim guidance has been developed with available information from similar coronaviruses. CDC states that decisions to discontinue Transmission-based Precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. Discontinuation will be based on multiple factors (see current CDC guidance for further details).

Note: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present.

**Other considerations for facilities:**

- Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>
- Increase the availability and accessibility of alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc.

- Ensure ABHS is accessible in all resident-care areas including inside and outside resident rooms.
- Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.
- Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility.
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse's stations, phones, internal radios, etc.).

**What other resources are available for facilities to help improve infection control and prevention?**

CMS urges providers to take advantage of several resources that are available:

**CDC Resources:**

- Infection preventionist training: <https://www.cdc.gov/longtermcare/index.html>
- CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>
- CDC Updates: <https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html>
- CDC FAQ for COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html>

**CMS Resources:**

- Long term care facility – Infection control self-assessment worksheet: [https://qsep.cms.gov/data/252/A\\_NursingHome\\_InfectionControl\\_Worksheet\\_11-8-19508.pdf](https://qsep.cms.gov/data/252/A_NursingHome_InfectionControl_Worksheet_11-8-19508.pdf)
- Infection control toolkit for bedside licensed nurses and nurse aides (“Head to Toe Infection Prevention (H2T) Toolkit”): <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment>
- Infection Control and Prevention regulations and guidance: 42 CFR 483.80, Appendix PP of the State Operations Manual. See F-tag 880: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>

**Contact:** Email [DN11\\_TriageTeam@cms.hhs.gov](mailto:DN11_TriageTeam@cms.hhs.gov)

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/  
David R. Wright

cc: Survey and Operations Group Management

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-16-Hospice

**DATE:** March 9, 2020  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Quality, Safety & Oversight Group  
**SUBJECT:** Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) by Hospice Agencies

Memorandum Summary

CMS is committed to protecting American patients by ensuring health care facilities have up-to-date information to adequately respond to COVID-19 concerns.

- **Coordination with the Centers for Disease Control and Prevention (CDC) and local public health departments** - We encourage all Hospice Agencies to monitor the CDC website for updated information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>).
- **Hospice Guidance and Actions** - CMS regulations and guidance support Hospice Agencies taking appropriate action to address potential and confirmed COVID cases and mitigate transmission including screening, treatment, and transfer to higher level care (when appropriate). This guidance applies to both Medicare and Medicaid providers.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to the protection of patients and residents of healthcare facilities or homecare settings from the spread of infectious disease. This memorandum responds to questions we have received and provides important guidance for Hospice Agencies in addressing the COVID-19 outbreak and minimizing transmission to other individuals.

Guidance

Hospice Agencies should regularly monitor the CDC website (see links below) for information and contact their local health department when needed (<https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html>). Also, hospice agencies should be monitoring the health status of patients, residents, visitors, volunteers, and staff under their care setting for signs or symptoms of

COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel, and visitors at the facility. For exposed staff, hospice agencies should consider frequent monitoring for potential symptoms of COVID-19 as needed throughout the day.

In addition to the overarching regulations and guidance, we have provided the following information (Frequently Asked Questions) about some specific areas related to COVID-19:

**Guidance for Addressing COVID-19 in Hospices (In-patient units, nursing facilities, assisted living, hospitals and home settings)**

**Which patients are at risk for severe disease from COVID-19?**

Based upon CDC data, older adults, those with underlying chronic or life-limiting medical conditions such as hospice patients are presumed to be at greater risk of poor outcomes when infected with novel coronavirus.

Refer to the CDC guidance for people at higher risk: <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html>

**How should providers screen visitors and patients for COVID-19 in a Hospice that provides short-term inpatient care directly or in an inpatient unit of another facility?**

Hospices should identify volunteers, visitors and patients at risk for having COVID-19 infection before or immediately upon arrival to the inpatient unit. They should be asked about the following:

1. International travel within the last 14 days to countries with sustained community transmission. For updated information on affected countries visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>
2. Signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat.
3. In the last 14 days, has had contact with someone with or under investigation for COVID-19, or are ill with respiratory illness.
4. Residing in a community where community-based spread of COVID-19 is occurring.

For patients with respiratory symptoms, implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient's nose and mouth) and isolate the patient in a private room with the door closed. If the patient cannot be immediately moved to an private location, ensure they are not allowed to wait among other patients who reside in the inpatient unit. Identify a separate, well-ventilated space that allows patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies.

Medicare requires Hospice Agencies to provide appropriate medical supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, facemasks, and tissues at healthcare facility entrances.

Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a person under investigation

(PUI) for COVID-19. For hospice patients with symptoms, determination about whether or not to conduct diagnostic testing versus presuming a positive COVID-19 diagnosis (based on his/her symptoms and exposure) should be a decision among the patient, patient representative, hospice agency and state and local public health authority. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC [COVID-19 website](#).

**How should hospice programs monitor or restrict health care staff or hospice volunteers?**

The same screening performed for patients and visitors should be performed for hospice staff and volunteers.

- Health care providers (HCP) and volunteers who have signs and symptoms of a respiratory infection should not report to work.
- Anyone that develop signs and symptoms of a respiratory infection while on-the-job, should:
  - Immediately stop work, put on a facemask, and self-isolate at home;
  - Inform the hospice's infection control manager/team to include information on individuals, equipment, and locations the person came in contact with; and
  - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel or volunteers from reporting to work (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>).

Hospices should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html>).

**When a hospice patient is in an inpatient unit, what are recommended infection prevention and control practices, including considerations for patient placement, when evaluating and care for a patient with known or suspected COVID-19?**

Recommendations for patient placement and other detailed infection prevention and control recommendations are available in the <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.

Consider, where appropriate allowing certain types of volunteer activities to be performed via phone or other electronic devices to minimize risk of exposure in the event of a suspected or positive COVID-19 case.

**Do hospice patients with known or suspected COVID-19 infection require hospitalization?**

Hospice patients and/or their families should carefully discuss care options with the hospice team to ensure the goals and wishes of hospice patient are respected consistent with patient rights requirements. Patients can be managed at home if the patient is stable, the environmental exposure to COVID-19 to others in the household can be minimized, and if there are appropriate infection control precautions made and PPE available.

Patients whose symptoms are exacerbated by COVID-19 and cannot be adequately managed in the home setting, should be transferred to a hospice inpatient unit. More information is available here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html>.

### **When is it safe to discontinue Transmission-based Precautions inpatient hospice patients with COVID-19?**

The decision to discontinue Transmission-Based Precautions for hospitalized patients with COVID-19 should be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. This decision should consider disease severity, illness signs and symptoms, and results of laboratory testing for COVID-19 in respiratory specimens.

Currently, negative RT-PCR results from at least 2 consecutive sets of nasopharyngeal and throat swabs collected at least 24 hours apart are needed before discontinuing Transmission-Based Precautions. A total of four negative specimens are needed to meet this requirement.

More detailed information about criteria to discontinue Transmission-Based Precautions are available here: <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/disposition-hospitalized-patients.html>.

### **When is it safe to discontinue in-home isolation for in home hospice patients with COVID-19?**

The decision should be made on a case-by-case basis in consultation with clinicians and public health officials. This decision should consider disease severity, illness signs and symptoms, and results of laboratory testing for COVID-19 in respiratory specimens

Guidance for discontinuation of in-home isolation precautions is the same as that to discontinue Transmission-Based Precautions for hospitalized patients with COVID-19. **For more information, see:** <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/disposition-in-home-patients.html>

Considerations to discontinue in-home isolation include all of the following:

- Resolution of fever, without use of antipyretic medication
- Improvement in illness signs and symptoms
- Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive sets of paired nasopharyngeal and throat swabs specimens collected  $\geq 24$  hours apart (total of four negative specimens-- two nasopharyngeal and two throat). See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation \(PUIs\) for 2019 Novel Coronavirus \(2019-nCoV\)](#) for specimen collection guidance.

### **Can hospices restrict visitation of patients (in-patient unit provided directly by the hospice)?**

Medicare regulations require a hospice to focus on preventing and controlling infections. Hospices may have policies regarding the visitation rights of patients and may wish to set clinical restrictions on visitation subject to patient's rights. If the inpatient hospice is not provided by the hospice itself (such as a hospital), that provider may have established additional visitation restrictions associated with that setting to address COVID-19 transmission concerns.

### **What are the considerations when caring for a hospice patient in their home?**

For hospice patients with known or suspected COVID-19 who remain in their homes, there are a number of infection prevention and control practices that should be followed. The CDC advises the patient to stay home except to get medical care, separate yourself from other people and animals in the home as much as possible (in a separate room with the door closed), call ahead before visiting your doctor, and wear a facemask in the presence of others when out of the patient room.

For everyone in the home, CDC advises covering coughs and sneezes followed by washing your hands or using an alcohol-based hand rub, not sharing personal items (dishes, eating utensils, bedding) with individuals with known or suspected COVID-19, cleaning all “high-touch” surfaces everyday, and monitoring your symptoms. Please see:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html>

CMS regulations also require that hospice agencies provide the types of necessary supplies and equipment required by the individualized plan of care. For a patient with COVID-19, this would include supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS). However, given supply shortages, State and Federal surveyors should not cite hospice agencies for not providing certain supplies (e.g., personal protective equipment (PPE) such as gowns, N95 respirators, surgical masks and alcohol-based hand rubs (ABHR)) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect providers/suppliers to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible.

### **What Personal Protective Equipment should hospice staff routinely use when visiting the home of a patient suspected of COVID-19 exposure or confirmed exposure?**

If care provided to symptomatic patients who are confirmed or presumed to be COVID-19 positive is anticipated, then Hospice Agencies should refer to the CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

Health care professionals who enter the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a facemask or respirator, gown, gloves, and eye protection. When available, respirators (instead of facemasks) are preferred; they should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring Airborne Precautions (e.g., tuberculosis, measles, varicella).

### **What are the considerations for discharge to a subsequent care location for hospice patients with COVID-19?**

The decision should be made based on the clinical condition of the patient including careful consultation with the patient, patient representatives and/or their family, and understanding their individual needs and goals of care. If Transmission-Based Precautions must be continued in the subsequent setting, the receiving facility must be able to implement all recommended infection prevention and control recommendations. Be sure the transportation team is aware that the patient has confirmed COVID-19.

Although COVID-19 patients with mild symptoms may be managed at home, the decision to discharge to home should consider the patient's ability to adhere to isolation recommendations, as well as the potential risk of secondary transmission to household members with immunocompromising conditions. More information is available here:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html>.

If hospice care is provided in a nursing home, we have advised nursing homes that hospice workers should be allowed entry provided that hospice staff is following the appropriate CDC guidelines for Transmission-Based Precautions, and using PPE properly.

### **Important CDC Resources:**

#### **CDC Resources for Health Care Facilities:**

- CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>
- CDC Updates: <https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html>
- CDC FAQ for COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html>
- Strategies for Optimizing the Supply of N95 Respirators: [https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html?CDC\\_AA\\_reVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Frespirator-supply-strategies.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html?CDC_AA_reVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Frespirator-supply-strategies.html)

#### **CDC Updates:**

<https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html>

Sign up for the newsletter to receive weekly emails about the coronavirus disease 2019 (COVID-19) outbreak.

#### **FDA Resources:**

- Emergency Use Authorizations: <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations>

#### **CMS Resources:**

Hospice Infection Control and Prevention regulations and guidance: 42 CFR 418.60, Infection Control, Appendix M of the State Operations Manual, Infection Prevention and Control.

[https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_m\\_hospice.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf).

**Contact:** Questions about this memorandum should be addressed to [QSOCI\\_EmergencyPrep@cms.hhs.gov](mailto:QSOCI_EmergencyPrep@cms.hhs.gov). Questions about COVID-19 guidance/screening criteria should be addressed to the State Epidemiologist or other responsible state or local public health officials in your state.

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/  
David R. Wright

cc: Survey and Operations Group Management

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Quality, Safety and Oversight Group

Ref: QSO-20-15 Hospital/CAH/EMTALA

**DATE:** March 9, 2020

**TO:** State Survey Agency Directors

**FROM:** Director  
Quality Safety and Oversight Group

**SUBJECT:** Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Coronavirus Disease 2019 (COVID-19)

Memorandum Summary

**COVID-19 and EMTALA Requirements:** This Memorandum conveys information in response to inquiries from hospitals and critical access hospitals (CAHs) concerning implications of COVID-19 for their compliance with EMTALA. This guidance applies to both Medicare and Medicaid providers.

- **EMTALA Screening Obligation:** Every hospital or CAH with a dedicated emergency department (ED) is required to conduct an appropriate medical screening examination (MSE) of all individuals who come to the ED, including individuals who are suspected of having COVID-19, and regardless of whether they arrive by ambulance or are walk-ins. Every ED is expected to have the capability to apply appropriate COVID-19 screening criteria when applicable, to immediately identify and isolate individuals who meet the screening criteria to be a potential COVID-19, to contact their state or local public health officials to determine next steps.
- **EMTALA Stabilization, Transfer & Recipient Hospital Obligations:** In the case of individuals with suspected or confirmed COVID-19, hospitals and CAHs are expected to consider current guidance of CDC and public health officials in determining whether they have the capability to provide appropriate isolation required for stabilizing treatment and/or to accept appropriate transfers. In the event of any EMTALA complaints alleging inappropriate transfers or refusal to accept appropriate transfers, CMS will take into consideration the public health guidance in effect at the time.

**Background**

Due to increasing public concerns with COVID-19, CMS is receiving inquiries from the hospital industry concerning implications for their compliance with EMTALA. Concerns center around

the ability of hospitals and CAHs to fulfill their EMTALA screening obligations while minimizing the risk of exposure from COVID-19 infected individuals to others in the ED, including healthcare workers, and the isolation requirements for COVID-19. In addition, we have also received questions about the applicability of EMTALA stabilization, transfer and recipient hospital obligations in the case of individuals who are found to have met the screening criteria for possible COVID-19 infection or who have been determined to have COVID-19.

Please note this memorandum applies to both hospital and critical access hospital (CAH) wherever “hospital” is referenced.

EMTALA requires Medicare-participating hospitals and CAHs that have a dedicated emergency department to, at a minimum:

- Provide a medical screening exam (MSE) to every individual who comes to the ED for examination or treatment for a medical condition to determine if they have an emergency medical condition (EMC). An emergency medical condition is present when there are acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in serious impairment or dysfunction.
- Provide necessary stabilizing treatment for individuals with an emergency medical condition EMC within the hospital’s capability and capacity; and
- Provide for transfers of individuals with EMCs, when appropriate.

Please see *Attachment 1* for a discussion of alternate screening locations and increased surges in numbers of patients presenting to the ED.

***Are hospitals required to accept transfers of patients with suspected or confirmed COVID-19 from small or rural hospitals that don’t have appropriate or sufficient isolation facilities or equipment to meet current state or local public health or CDC recommendations?***

Hospitals with capacity and the specialized capabilities needed for stabilizing treatment are required to accept appropriate transfers from hospitals without the necessary capabilities. Hospitals should coordinate with their State/local public health officials regarding appropriate placement of individuals who meet specified COVID-19 assessment criteria, and the most current standards of practice for treating individuals with confirmed COVID-19 infection status.

As in any case concerning a hospital’s EMTALA obligations with respect to transfers of individuals, CMS would evaluate the capabilities and capacity of both the referring and recipient hospitals in order to determine whether a violation has occurred. Among other things, we would take into account the CDC’s recommendations at the time of the event in question in assessing whether a hospital had the requisite capabilities and capacity. We note that the CDC’s recommendations focus on factors such as the individual’s recent travel or exposure history and presenting signs and symptoms in differentiating the types of capabilities hospitals should have to screen and treat that individual. The presence or absence of negative pressure rooms (Airborne Infection Isolation Room (AIIR)) would not be the sole determining factor related to transferring patients from one setting to another when in some cases all that would be required would be a private room. See the CDC website for the most current infection prevention and

control recommendations for hospital patients with suspected or known COVID-19:  
<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-guidance-management-patients.html>

In addition, all Medicare-participating hospitals with specialized capabilities are required to accept appropriate transfers of individuals with EMCs if the hospital has the specialized capabilities an individual requires for stabilization as well as the capacity to treat these individuals. This recipient hospital obligation applies regardless of whether the hospital has a dedicated emergency department.

*What are the screening sites that may be set up?*

**Hospitals may set up alternative screening sites on campus**

- The MSE does not have to take place in the ED. A hospital may set up alternative sites on its campus to perform MSEs.
  - Individuals may be redirected to these sites after being logged in. The redirection and logging can even take place outside the entrance to the ED.
  - The person doing the directing should be qualified (e.g., an RN) to recognize individuals who are obviously in need of immediate treatment in the ED.
- The content of the MSE varies according to the individual's presenting signs and symptoms. It can be as simple or as complex, as needed, to determine if an EMC exists.
- MSEs must be conducted by qualified personnel, which may include physicians, nurse practitioners, physician's assistants, or RNs trained to perform MSEs and acting within the scope of their State Practice Act.
- The hospital must provide stabilizing treatment (or appropriate transfer) to individuals found to have an EMC, including moving them as needed from the alternative site to another on-campus department.

***B. Hospitals may set up screening at off-campus, hospital-controlled sites.***

- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for influenza-like illness (ILI). *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE.*
- Unless the off-campus site is already a dedicated ED (DED) of the hospital, as defined under EMTALA regulations, EMTALA requirements do not apply.
- The hospital should not hold the site out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis. They can hold it out as an ILI screening center.
- The off-campus site should be staffed with medical personnel trained to evaluate individuals with ILIs.
- If an individual needs additional medical attention on an emergent basis, the hospital is required, under the Medicare Conditions of Participation, to arrange

referral/transfer. Prior coordination with local emergency medical services (EMS) is advised to develop transport arrangements.

### **C. Communities may set up screening clinics at sites not under the control of a hospital**

- There is no EMTALA obligation at these sites.
- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for ILI. *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE.*
- Communities are encouraged to staff the sites with medical personnel trained to evaluate individuals with ILIs.
- In preparation for a pandemic, the community, its local hospitals and EMS are encouraged to plan for referral and transport of individuals needing additional medical attention on an emergent basis.

### **EMTALA Obligations when Screening Suggests Possible COVID-19**

If an individual comes to an ED of a hospital, as the term “comes to the emergency department” is defined in the regulation at §489.24(b), either by ambulance or as a walk-in, the hospital must provide the individual with an appropriate MSE. We emphasize that it is a violation of EMTALA for hospitals and CAHs with EDs to use signage that presents barriers to individuals who are suspected of having COVID-19 from coming to the ED, or to otherwise refuse to provide an appropriate MSE to anyone who has come to the ED for examination or treatment of a medical condition. However, use of signage designed to help direct individuals to various locations on the hospital property, as that term is defined in the regulation at §489.24(b), for their MSE would be acceptable. If the hospital is intending to use another location to conduct the MSE, please see *Attachment 1* for additional information.

If during the MSE the hospital concludes that an individual who has come to its ED may be a possible COVID-19 case, consistent with accepted standards of practice for COVID-19 screening, the hospital is expected to isolate the patient immediately. Although levels of services provided by EDs vary greatly across the country, it is CMS’ expectation that all hospitals are able to, within their capability, provide MSEs and initiate stabilizing treatment, while maintaining the isolation requirements for COVID-19 and coordinating with their State or local public health officials, who will in turn arrange coordination, as necessary, with the CDC.

Stabilizing treatment means, with respect to an “emergency medical condition”, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to occur. Once an individual is admitted or the emergency medical condition ends, the obligations under EMTALA end.

At the time of this memo’s publication, CDC’s screening guidance (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>) called for hospitals to contact their State or local public health officials when they have a case of suspected COVID-19. Officials will advise of next steps, in accordance with CDC recommendations on testing.

### **Other Enforcement Considerations**

Should CMS receive complaints alleging either inappropriate transfers by a sending hospital or refusal of a recipient hospital to accept an appropriate transfer, it will take into consideration CDC guidance and State or local public health direction at the time of the alleged noncompliance. It will also take into consideration any clinical considerations specific to the individual case(s).

Consistent with their obligations under the hospital and CAH Conditions of Participation (CoPs) §482.42 and §485.640, hospitals and CAHs are expected to adhere to accepted standards of infection control practice to prevent the spread of infectious disease and illness, including COVID-19. Standard, contact, and airborne precautions with eye protection should be used when caring for the patient as noted in CDC's [Interim Health Care Infection Prevention and Control Recommendations for Patients Under Investigation for Coronavirus Disease 2019 \(COVID-19\)](#). The CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to follow this guidance. CMS recognizes the difficulties securing the recommended personal protective equipment (PPE) required for training and patient care that may be present in some circumstances at the time of this memorandum.

Hospitals and CAHs are expected under their respective CoPs at §482.11(a) and §485.608(a) to comply with Occupational Safety and Health Administration (OSHA) requirements, but CMS and state surveyors acting on its behalf do not assess compliance with requirements of other Federal agencies.

### **Latest CDC Guidance**

The most up-to-date guidance regarding screening, testing, treatment, isolation, and other COVID-19 topics can be found on the CDC website at <https://emergency.cdc.gov/han/HAN00427.asp>. Hospitals and CAHs are strongly urged to monitor this site as well as their State public health website and follow recommended guidelines and acceptable standards of practice. State Survey Agencies are also encouraged to monitor the CDC and their state public health websites for up-to-date information.

### **CMS Resources**

CMS has released a memo regarding triage, assessment and discharge for hospitals which will provide additional information about responding to COVID-19 cases. <https://www.cms.gov/files/document/qso-20-13-hospitalspdf.pdf-2>

CMS has additional guidance which may be beneficial related to EMTALA, and other topics surrounding health standards and quality. The document Provider Survey and Certification Frequently Asked Questions (FAQs), Declared Public Health Emergency All-Hazards are located at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/All-Hazards-FAQs.pdf>. These FAQs are not limited to situations involving 1135 Waivers, but are all encompassing FAQs related to public health emergencies and survey activities and functions.

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Questions about this memo should be addressed to QSOG\_EmergencyPrep@cms.hhs.gov.

**FDA Resources:**

- Emergency Use Authorizations: <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations>

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers, and the State/Regional Office training coordinators immediately.

/s/

David Wright

cc: Survey & Certifications Group Management

Attachment (2)

**FACT SHEET**



**Emergency Medical Treatment and Labor Act (EMTALA) &  
Surges in Demand for Emergency Department (ED) Services**

**I. What is EMTALA?**

- EMTALA is a Federal law that requires all Medicare-participating hospitals (**including critical access hospitals (CAHs)**) with dedicated EDs to perform the following for **all** individuals who come to their EDs, regardless of their ability to pay:
  - An *appropriate* medical screening exam (MSE) to determine if the individual has an Emergency Medical Condition (EMC). If there is no EMC, the hospital's EMTALA obligations end.
  - If there is an EMC, the hospital must:
    - + Treat and stabilize the EMC within its capability (including inpatient admission when necessary); **OR**
    - + Transfer the individual to a hospital that has the capability and capacity to stabilize the EMC.
- Hospitals with specialized capabilities (with or without an ED) may not refuse an appropriate transfer under EMTALA if they have the capacity to treat the transferred individual.
- EMTALA ensures access to hospital emergency services; it need not be a barrier to providing care in a disaster.

**II. Options for Managing Extraordinary ED Surges Under Existing EMTALA Requirements (No Waiver Required)**

**A. Hospitals may set up alternative screening sites on campus**

- The MSE does not have to take place in the ED. A hospital may set up alternative sites on its campus to perform MSEs.
  - Individuals may be redirected to these sites after being logged in. The redirection and logging can even take place outside the entrance to the ED.
  - The person doing the directing should be qualified (e.g., an RN) to recognize individuals who are obviously in need of immediate treatment in the ED.
- The content of the MSE varies according to the individual's presenting signs and symptoms. It can be as simple or as complex, as needed, to determine if an EMC exists.

- MSEs must be conducted by qualified personnel, which may include physicians, nurse practitioners, physician's assistants, or RNs trained to perform MSEs and acting within the scope of their State Practice Act.
- The hospital must provide stabilizing treatment (or appropriate transfer) to individuals found to have an EMC, including moving them as needed from the alternative site to another on-campus department.

**B. Hospitals may set up screening at off-campus, hospital-controlled sites.**

- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for influenza-like illness (ILI). *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE.*
- Unless the off-campus site is already a dedicated ED (DED) of the hospital, as defined under EMTALA regulations at 42 CFR § 489.24(b), EMTALA requirements do not apply.
- The hospital should not hold the site out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis. They can hold it out as an ILI screening center.
- The off-campus site should be staffed with medical personnel trained to evaluate individuals with ILIs.
- If an individual needs additional medical attention on an emergent basis, the hospital is required, under the Medicare Conditions of Participation, to arrange referral/transfer. Prior coordination with local emergency medical services (EMS) is advised to develop transport arrangements.

**C. Communities may set up screening clinics at sites not under the control of a hospital**

- There is no EMTALA obligation at these sites.
- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for ILI. *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE.*
- Communities are encouraged to staff the sites with medical personnel trained to evaluate individuals with ILIs.
- In preparation for a pandemic, the community, its local hospitals and EMS are encouraged to plan for referral and transport of individuals needing additional medical attention on an emergent basis.

**III. EMTALA Waivers**

- An EMTALA waiver allows hospitals to:
  - Direct or relocate individuals who come to the ED to an alternative off-campus site, in accordance with a State emergency or pandemic preparedness plan, for the MSE.

- Effect transfers normally prohibited under EMTALA of individuals with unstable EMCs, so long as the transfer is necessitated by the circumstances of the declared emergency.
- By law, the EMTALA MSE and stabilization requirements can be waived for a hospital **only if**:
  - The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act ; *and*
  - The Secretary of HHS has declared a Public Health Emergency; *and*
  - The Secretary invokes her/his waiver authority (which may be retroactive), including notifying Congress at least 48 hours in advance; *and*
  - The waiver includes waiver of EMTALA requirements and the hospital is covered by the waiver.
- CMS will provide notice of an EMTALA waiver to covered hospitals through its Regional Offices and/or State Survey Agencies.
- Duration of an EMTALA waiver:
  - In the case of a public health emergency involving pandemic infectious disease, until the termination of the declaration of the public health emergency; *otherwise*
  - In all other cases, 72 hours after the hospital has activated its disaster plan.
  - In no case does an EMTALA waiver start before the waiver's effective date, which is usually the effective date of the public health emergency declaration.

## **EMTALA Obligations & 2019-Novel Coronavirus (COVID-19) Question and Answer Document**

*Note: For the purpose of this document, the term “hospital” includes all types of Medicare-participating hospitals, critical access hospitals (CAHs).*

### **A. Patient Insurance/Payor Status**

***A.1. Is a Medicare-participating hospital required to provide EMTALA-mandated screening and stabilizing treatment for non-Medicare beneficiaries with likely or confirmed COVID-19?***

EMTALA applies to all individuals who come to the dedicated emergency department (ED) of a Medicare-participating hospital or CAH, regardless of type or presence of insurance coverage or ability to pay. Further, Medicare-participating hospitals with specialized capabilities are required within the limits of their capability and capacity to accept appropriate transfers of individuals protected under EMTALA from other hospitals, without regard to insurance or ability to pay.

### **B. Specialized Capabilities**

***B.1. EMTALA requires that hospitals with specialized capabilities to treat COVID-19 accept appropriate transfers of individuals who require those services, if they have capacity to provide them. In the event of an EMTALA complaint related to an inappropriate transfer and/or a refusal of a recipient hospital to accept an appropriate transfer, how will CMS determine whether a hospital had the “specialized capabilities” with respect to COVID-19 required by the individual?***

At the time of this FAQ document, no formally designated COVID-19 treatment centers are established. Some of the early COVID-19 cases were sent to hospitals previously designated as Ebola treatment centers however, no determination has been made that specialized centers would be developed for COVID-19 cases and therefore all hospitals are required at a minimum to screen, isolate, and begin stabilizing treatment as appropriate for any individual with suspected COVID-19 symptoms.

***B.2: Are hospitals required to accept transfers of patients with suspected or confirmed COVID-19 from small or rural hospitals that don’t have appropriate or sufficient isolation facilities or equipment to meet current state or local public health or CDC recommendations?***

Hospitals with capacity and the specialized capabilities needed for stabilizing treatment are required to accept appropriate transfers from hospitals without the necessary capabilities. Hospitals should coordinate with their State/local public health officials regarding appropriate placement of individuals who meet specified COVID-19 assessment criteria, and the most current standards of practice for treating individuals with confirmed COVID-19 infection status.

As in any case concerning a hospital’s EMTALA obligations with respect to transfers of individuals, CMS would evaluate the capabilities and capacity of both the referring and recipient hospitals in order to determine whether a violation has occurred. Among other things, we would take into account the CDC’s recommendations at the time of the event in question in assessing

whether a hospital had the requisite capabilities and capacity. We note that the CDC's recommendations focus on factors such as the individual's recent travel or exposure history and presenting signs and symptoms in differentiating the types of capabilities hospitals should have to screen and treat that individual. The presence or absence of negative pressure rooms (Airborne Infection Isolation Room (AIIR)) would not be the sole determining factor related to transferring patients from one setting to another when in some cases all that would be required would be a private room. See the CDC website for the most current infection prevention and control recommendations for hospital patients with suspected or known COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>

### **C. Screening Examinations and Stabilizing Treatment Requirements**

#### ***C.1: What are the EMTALA requirements for hospitals in regard to screening and treating individuals with possible COVID-19?***

The EMTALA requirements for hospitals and CAHs are the same for individuals with possible COVID-19 symptoms as all other possible emergency medical conditions (EMCs). Hospitals and CAHs must:

- Provide an appropriate Medical Screening Exam (MSE) to every individual who comes to the Emergency Department (ED) for examination or treatment of a medical condition, to determine if they have an emergency medical condition (EMC); Provide necessary stabilizing treatment for individuals with an EMC within the hospital's capability and capacity; and
- Provide for appropriate transfers of individuals with EMCs if the hospital lacks the capability to stabilize them.

Specific to COVID-19, hospitals are encouraged to follow the CDC guidance for appropriate isolation procedures to minimize the risk of cross-contamination to other patients, visitors, and healthcare workers. For example, the CDC publishes and updates guidance related to COVID-19. Hospitals should consult the latest CDC guidance and coordinate with State/local public health authorities for guidance related to ongoing care and treatment of patients with COVID-19.

#### ***C.2: Are all hospitals expected to screen and treat individuals with possible COVID-19 symptoms?***

Yes, all hospitals are expected, at a minimum to screen, isolate, and begin stabilizing treatment, as appropriate, for any individual with possible COVID-19 symptoms. Hospitals should coordinate with their State/local public health authorities regarding ongoing care and treatment.

#### ***C.3: Can hospitals ask patients to wait in their car or outside the hospital as CDC suggests in their COVID-19 guidance or is that violating EMTALA?***

The MSE requirement of EMTALA requires that it be timely depending on the presenting signs and symptoms of the individual. Hospitals must perform an appropriate examination by a Qualified Medical Practitioner to determine if the patient has an emergency medical condition. If the individual, after an appropriate medical screening exam, meets the CDC criteria for potential COVID-19 and is determined to have no signs or symptoms that require immediate medical attention, then this would not present a direct EMTALA violation. In cases where a request is

made for medical care that is unlikely to involve an EMC, the individual's statement that s/he is not seeking emergency care, together with brief questioning by the QMP would be sufficient to establish that there is no EMC and the hospital's EMTALA obligation would be satisfied. However, the hospital should have a system in place to monitor those patients that opt to wait in their own vehicle to ensure that their condition has not deteriorated while awaiting further evaluation. Failure to do so could expose the hospital to a potential MSE violation because the MSE was not done timely. In that case, it could also be a violation of the Condition of Participation: Emergency Services. As noted during previous public health emergency situations such as EBOLA and H1N1, CMS will take into consideration any clinical considerations specific to the individual case(s).

***C.4: If a hospital does not have Intensive Care Unit (ICU) capabilities is it required to screen and, when appropriate, initiate stabilizing treatment for individuals with suspected or confirmed COVID-19?***

Yes. The lack of ICU capabilities does not exempt a hospital from performing an MSE and initiating stabilizing treatment for individuals with known or suspected COVID-19 who come to the hospital's ED seeking examination or treatment. Qualified medical personnel in hospitals that conduct the screening examination should be aware of the criteria for initial COVID-19 screening and should apply such screening when appropriate. Note that the CDC guidance for COVID-19, indicates that they should do the following:

- Promptly identify and triage patients with relevant exposure history AND signs or symptoms compatible with COVID-19 <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.
- Immediately isolate any patient with relevant exposure history and signs or symptoms compatible with COVID-19 and take appropriate steps to adequately protect staff caring for the patient, including appropriate use of personal protective equipment (PPE).
- Immediately notify the hospital/facility infection control program, other appropriate facility staff, and the state and local public health agencies that a patient has been identified who has relevant exposure AND signs or symptoms compatible with COVID-19.

***C.5: May hospitals refuse to allow individuals with suspected cases of COVID-19 into their ED?***

No. For every individual who "comes to the emergency department," as that term is defined in §489.24(b) of the EMTALA regulations, for evaluation or treatment of a medical condition, whether by ambulance or by walking-in, hospitals are required to provide an appropriate medical screening examination. Qualified medical personnel in hospitals that conduct the screening examination should be aware of the criteria for initial COVID-19 screening and should apply such screening when appropriate. Hospitals that refuse to screen an individual who comes to their emergency department would likely be found to have violated EMTALA, regardless of presenting signs, symptoms, and possible diagnoses.

***C.6: If a hospital remains open during COVID-19 or any other infectious outbreak, and is operating at or in excess of its normal operating capacity and cannot get sufficient staff, may the hospital shut down its emergency department (ED) without violating EMTALA?***

Under these circumstances, EMTALA would not prohibit the hospital from closing its ED to new patients if it no longer had the capacity to screen and treat individuals (in effect, going on diversion). The hospital should follow any applicable State and local notice requirements and its own previously established plan for public notification when it goes on diversionary status. The hospital would continue to have an EMTALA obligation to individuals undergoing examination or treatment in its ED at the time it stops accepting new emergency patients. In addition, in spite of the “closure” if an individual comes to such a hospital and requests examination or treatment for an emergency medical condition, the hospital would be obligated by EMTALA to act within its capabilities to provide screening and, if necessary, stabilization.

***C.7: Are all hospitals expected to have Personal Protective Equipment (PPE) and other equipment/facilities to screen and take care of suspected or confirmed COVID-19 patients?***

There are no requirements established under EMTALA for hospitals to have specific PPE or equipment/facilities. Consistent with their obligations under the hospital and CAH Conditions of Participation (CoPs) at §482.42 and §485.640, hospitals and CAHs are expected to adhere to accepted standards of infection control practice to prevent the spread of COVID-19. However, the Emergency Preparedness Final Rule requires an all-hazards approach to the emergency preparedness planning and program. In February 2019, CMS updated subregulatory guidance in Appendix Z of the State Operations Manual (SOM), for facilities to plan for using an all-hazards approach, to include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others. Under this guidance, CMS specifically stated that these EIDs may require modifications to facility protocols to protect the health and safety of patients, such as isolation and personal protective equipment (PPE) measures.

The CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to follow this guidance.

***C.8: May hospitals decline to perform an MSE on an individual who comes to their ED with potential or suspected COVID-19 due to a lack of PPE or specialized equipment/facilities?***

No. For every individual who “comes to the emergency department,” as that term is defined in §489.24(b) of the EMTALA regulations, for evaluation or treatment of a medical condition, whether by ambulance or by walking-in, hospitals are required to provide an appropriate medical screening examination. Qualified medical personnel in hospitals that conduct the screening examination must be aware of the criteria for initial COVID-19 screening and apply such screening when appropriate. Hospitals that refuse to screen an individual who comes to their emergency department would likely be found to have violated EMTALA, regardless of presenting signs, symptoms, and possible diagnoses.

***C.9: Will CMS issue EMTALA waivers for hospitals related to COVID-19?***

The statute governing EMTALA waivers sets a high threshold for issuing such waivers and also limits the nature and duration of an EMTALA waiver. At this time the requirements for CMS to issue EMTALA waivers have not been met (i.e., issuance of a Presidential disaster declaration and a Secretary's declaration of a public health emergency). For additional information, please visit <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers>.

***C.10: What about ambulances operating under emergency medical services (EMS) systems – are they subject to EMTALA?***

Public health officials, EMS systems and hospitals are free to develop protocols governing where EMS should transport individuals for emergency care. This includes developing protocols specific to individuals who meet criteria to be considered suspected cases of COVID-19. A hospital owned and operated ambulance operating under communitywide protocols that direct transport of individuals to a hospital other than the hospital that owns the ambulance, for example, to the closest appropriate hospital, the individual is considered to have come to the ED of the hospital to which the individual is transported, at the time the individual is brought onto hospital property and the hospital becomes subject to EMTALA.

Even in the case of ambulances that are owned and operated by a hospital, it is permissible to transport an individual to a different hospital for screening and treatment, so long as they are operating in accordance with a communitywide EMS protocol, or they are operating under the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance.

***C.11: May hospitals set up alternative screening sites within the hospital to screen possible COVID-19 patients, even if they don't have an EMTALA waiver?***

Yes, hospitals have flexibilities to set up alternative screening sites at other parts of the hospital, both on- and off-campus. See *Attachment 1* for additional guidance regarding surges in emergency department services.

Additionally, per the Medicare Conditions of Participation, hospitals must have policies and procedures based on the facility's emergency preparedness plan and its role under a waiver declared by the HHS Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by public health and emergency management officials. While we recognize at the time of these FAQs, an 1135 Waiver cannot be invoked as only the HHS Secretary has declared a public health emergency, we do expect facilities to have policies and procedures on alternate care sites.

However, absent an EMTALA waiver issued by CMS pursuant to a declaration of a public health emergency, hospitals may not direct an individual who has already come to their on-site emergency department to any off-campus location for screening.

***C.11(a): What constitutes an alternative hospital location? For instance, can this include a tarped-off area of another room, a room constructed in the ambulance bay, or the room previously used as the decontamination room?***

Hospitals have flexibilities under EMTALA to determine alternative locations outside the ED but within the hospital or on the hospital's property for screening examinations of individuals potentially exposed to or infected with COVID-19. Please see the Attachment 1: Fact Sheet for Addressing Hospital Surges

***C.11(b): Do the Life Safety Code (LSC) requirements under the hospital or critical access hospital Conditions of Participation apply to alternative care sites?***

Since alternative care sites are expected to be within the hospital or on the hospital's property (operating as part of the hospital/under the hospital's CMS Certification Number, they would be expected to meet LSC requirements. However, there may be situations where temporary examination areas are set up (please refer to above on alternate care sites).

Additionally, if compliance issues come up in such localized situations where no applicable section 1135 waiver [for declared public health emergencies] is available, CMS focuses on fundamentals, such as assuring medical and nursing staff have proper credentials and, in the case of medical staff, have privileges; assuring that care is safe, that patients' rights are protected and that medical records with sufficient information to promote safe care are maintained. Additionally, for facilities subject to the Life Safety Code (LSC), past experience has demonstrated that many facilities, even when functioning in a degraded status, or in the case of the establishment of alternative care sites, may continue to meet the LSC by implementing reasonable and prudent measures. For example, there were several hospitals that were damaged by Hurricane Katrina which continued to comply with the LSC by implementing reasonable and prudent measures, and therefore were able to continue operations in a degraded but safe environment for weeks or months until repairs could be completed.

Archived information on H1N1 which discussed alternate care sites can be located at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertifEmergPrep/Downloads/SCLetter-10-06-Influenza.pdf>

We would also encourage facilities to review resources provided by the Assistant Secretary of Preparedness and Response (ASPR) Technical Resources Assistance Center and Information Exchange (TRACIE) located here: <https://asprtracie.hhs.gov/technical-resources/48/alternate-care-sites-including-shelter-medical-care/47>

***C.11(c): Can alternative sites include outbuildings on the campus or use of tents in the parking lot?***

Alternative screening sites may be located in other buildings on the campus of a hospital or in tents in the parking lot, as long as they are determined to be an appropriate setting for medical screening activities and meet the clinical requirements of the individuals referred to that setting. We also defer to screening guidance provided by the CDC.

***C.11(d): What would be an acceptable alternative location on campus? Must the location currently exist as a part of the certified facility?***

The location must be part of the certified hospital. If it is not currently part of the certified hospital, then the hospital must take steps to add the location as a new practice location of the hospital.

***C.11(e): What type of approval process needs to be in place for a hospital to use an alternative location?***

CMS does not require any approval process to use an alternative screening location that is already part of the certified hospital. If the hospital is adding a practice location, it must file a Form 855A with its Medicare Administrative Contractor to advise it of this action. The hospital is not required to obtain prior approval from CMS in order to bill Medicare for services at the added location. There is also no requirement for all added locations to be surveyed for compliance with the Medicare Hospital Conditions of Participation, but CMS retains the discretion to require a survey in individual cases.

States may have licensure requirements for prior approval of any additional practice locations, so hospitals are encouraged to consult with their State licensure authority on any applicable State requirements.

***C.11(f): In the past when there have been disasters that resulted in ED surges alternative locations needed to be submitted and approved by State licensure authorities and also by CMS. Does this hold true for alternative locations for screening of potential COVID-19 patients?***

See answer to the prior question. As stated, CMS does not require prior approval for hospitals that are adding a practice location. Hospitals should consult with their State licensure authority on any applicable State requirements.

#### **D. Patient Rights**

***D.1: What action should the hospital take if an individual who meets the screening criteria for suspected COVID-19 wants to leave the hospital against medical advice?***

Hospitals do not have authority to prevent the individual from leaving against medical advice. However, State or local public health authorities may have such authority under State or local law, and hospitals should coordinate with their local authorities on the appropriate way to handle an individual suspected of having COVID-19 who wants to leave the hospital environment.

Note that there is an EMTALA requirement at §489.24(d)(3) for a hospital to take all reasonable steps to secure the individual's written informed refusal (or that of the individual's representative) of further medical examination or treatment that the hospital has offered.

#### **E. Enforcement**

***E.1: What will CMS do when a survey reveals that a hospital is not following nationally recognized guidelines regarding COVID-19 infection control processes?***

EMTALA does not establish requirements for infection control practices. However, consistent with their obligations under the hospital and CAH Medicare CoPs at §482.42 and §485.640, hospitals and CAHs are expected to adhere to accepted standards of infection control practice and Medicare conditions.

The CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to follow this guidance. Hospitals may be cited for deficiencies under the CoPs related to failure to follow accepted infection prevention and control standards of practice. Hospitals should regularly check the official [CDC COVID-19 website](https://www.cdc.gov/coronavirus/2019-ncov/index.html) (<https://www.cdc.gov/coronavirus/2019-ncov/index.html>) and consider signing up for [Sign up for the newsletter](#) to receive weekly emails about the coronavirus disease 2019 (COVID-19)

[https://tools.cdc.gov/campaignproxyservice/subscriptions.aspx?topic\\_id\\_USCDC\\_2067](https://tools.cdc.gov/campaignproxyservice/subscriptions.aspx?topic_id_USCDC_2067).

***E.2: How will CMS handle complaints about violations of EMTALA related to transfers/attempts to transfer individuals suspected or confirmed as having COVID-19?***

If CMS receives complaints alleging either inappropriate transfers by a referring hospital or refusal of a recipient hospital to accept an appropriate transfer, the agency will consider the following (along with other factors) when making a determination of whether violations of EMTALA have occurred:

- The individual's clinical condition at the time of presentation to the referring hospital and at the time of the transfer request;
- The capabilities of the referring hospital,
- The screening and treatment activities performed by the referring hospital for the individual;
- Whether the request for transfer was consistent with any nationally recognized guidelines in effect at the time of the transfer request for COVID-19 screening, assessment, including guidance about transfer for further assessment or treatment of suspected or confirmed COVID-19; and,
- The capabilities of the recipient hospital and the recipient hospital's capacity at the time of the transfer request.

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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-19-ESRD

**DATE:** March 10, 2020

**TO:** State Survey Agency Directors

**FROM:** Director  
Quality, Safety & Oversight Group

**SUBJECT:** Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in dialysis facilities

Memorandum Summary

- **CMS is dedicated** to the continued health and safety of patients obtaining care within dialysis facilities to ensure facilities are prepared to respond to the threat of COVID-19.
- **Dialysis Guidance and Actions** - CMS is providing additional guidance to dialysis facilities to help them focus their infection control and prevention practices to prevent the transmission of COVID-19.
- **Coordination with the Centers for Disease Control (CDC) and local public health departments** - We encourage all dialysis facilities to monitor the CDC website for updated information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>).

Background

CMS is responsible for ensuring the health and safety within dialysis facilities by enforcing health and safety standards required to help facilities provide safe, quality care to dialysis patients. Due to the recent spread of COVID-19, we are providing additional guidance to dialysis facilities to help control and prevent the spread of the virus.

Guidance

Facilities should monitor the CDC website for information and resources (links below), and contact their local health department when needed. Also, facilities should be monitoring the health status of everyone (in-center and home dialysis patients/visitors/staff/etc.) in their facility for signs or symptoms of respiratory infection, including COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible exposed or

infected individuals. Facilities should consider frequent monitoring for potential symptoms of respiratory infection as needed throughout the day. Furthermore, we encourage facilities to take advantage of resources that have been made available by CDC and CMS to train and prepare staff to improve infection control and prevention practices. Lastly, facilities should maintain open lines of communication with patients, patient representatives and/or family and other care providers to respond to the individualized needs of each patient.

Facilities experiencing an increased number of respiratory illnesses (regardless of suspected etiology) among patients/visitors or healthcare personnel should immediately contact their local or state health department for further guidance.

In addition to the requirements in the Conditions for Coverage (CFC) and associated guidance, we're providing the following information (Frequently Asked Questions) about some specific areas related to COVID-19:

### **Guidance for Limiting the Transmission of COVID-19 for Dialysis Facilities**

#### **What actions should dialysis facilities implement to promote early recognition and management of patients, staff and visitors?**

Facilities should screen patients, staff and visitors and contact home dialysis patients for the following:

1. Signs or symptoms of a respiratory infection, such as a fever, cough, shortness of breath or sore throat.
2. Contact with someone with or under investigation for COVID-19.
3. International travel within the last 14 days to countries with widespread or ongoing community spread. For updated information on countries visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html>
4. Residing in a community where community-based spread of COVID-19 is occurring.

Furthermore, to promptly identify and manage patients, staff or visitors with undiagnosed respiratory symptoms the following actions should be implemented:

- Facilities should identify patients with signs and symptoms of respiratory infections before they enter the treatment area.
  - Patients with symptoms of a respiratory infection should put on a facemask (i.e., surgical mask) at check-in and keep it on until they leave the facility. The facility should provide if needed.
  - Patients should inform staff of fever or respiratory symptoms immediately upon arrival at the facility (e.g., when they check in at the registration desk) (Note, the facility will likely also check patient temperature).
  - Have patients call ahead to report fever or respiratory symptoms so the facility can be prepared for their arrival or triage them to a more appropriate setting (e.g., an acute care hospital).
  - Post signs at entrances with instructions to patients with fever or symptoms of respiratory infection to alert staff so appropriate precautions can be implemented.

- Facilities should provide patients and staff with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette.
  - Instructions should include how to use facemasks or tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene
- Facilities should have the following supplies available to ensure adherence to hand and respiratory hygiene, and cough etiquette. These include tissues and no-touch receptacles for disposal of tissues and hand hygiene supplies (e.g., alcohol-based hand sanitizer)
- Visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) should defer visitation until he or she is no longer potentially infectious (e.g., 24 hours after resolution of fever without antipyretic medication).

**How should facilities monitor or restrict dialysis facility staff?**

The same screening performed for visitors should be performed for facility staff (numbers 1, 2, and 3 above).

- Dialysis staff who have signs and symptoms of a respiratory infection should not report to work. Facilities should implement sick leave policies that are non-punitive, flexible and consistent with public health policies that allow ill staff members to stay home.
- Any staff member that develops signs and symptoms of a respiratory infection, should:
  - Immediately stop work (if working), put on a facemask, and self-isolate at home;
  - Inform the facility administrator, and collect information on individuals, equipment, and locations the person came in contact with; and
  - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>).

Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>).

**Where should dialysis facilities place patients with undiagnosed respiratory symptoms and/or suspected or confirmed COVID 19?**

Facilities should have space in waiting areas for ill patients to sit separated from other patients by at least 6 feet. Medically-stable patients who do not have other care needs have the option to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be seen. Additional placement consideration include:

- Patients with respiratory symptoms should be brought back to a designated treatment area for evaluation as soon as possible in order to minimize time in common waiting areas.

- Facilities should maintain at least 6 feet of separation between masked, symptomatic patients and other patients and stations during dialysis treatment. Ideally, symptomatic patients would be dialyzed in a separate room (if available) with the door closed.
  - Hepatitis B isolation rooms may be used to dialyze patients if:
    - The patient with suspected or confirmed COVID-19 is hepatitis B surface antigen positive or;
    - The facility has no hepatitis B surface antigen positive patients who would require treatment in the isolation room.
    - If a separate room is not available, the patient should be treated at a corner or end-of-row station, away from the main flow of traffic (if available). The patient should be separated by at least 6 feet from the nearest patient stations (in all directions).

When transmission in the community is identified, the local medical system's capacity to accept hemodialysis patients for treatment may be exceeded. Public health authorities and dialysis facilities should refer to pandemic and emergency preparedness plans to help determine alternatives. Alternative options may include the need to continue dialysis in the outpatient hemodialysis setting if the patient's condition does not require a higher level of care. If a hemodialysis facility is dialyzing more than one patient with suspected or confirmed COVID-19, consideration should be given to cohorting these patients and the dialysis staff caring for them together in the unit and/or on the same shift (e.g., consider the last shift of the day). Additionally, per current CDC guidance, an airborne infection isolation room (AIIR) is not required for the evaluation or care of patients with suspected or confirmed COVID-19. AIIRs should be prioritized for patients who are critically ill or receiving aerosol-generating procedures.

**What type of Personal Protective Equipment (PPE) should be used when caring for patients with undiagnosed respiratory symptoms?**

When providing dialysis care, facilities should continue to follow the infection control requirements at 42 CFR §494.30 including requirements for hand hygiene, PPE, isolation and routine cleaning and disinfection procedures.

- In general, dialysis staff caring for patients with undiagnosed respiratory infections should follow Standard, Contact, and Droplet Precautions with eye protection unless the suspected diagnosis requires Airborne Precautions (e.g., tuberculosis). This includes the use of:
  - Isolation gowns
    - The isolation gown should be worn over or instead of the cover gown (i.e., laboratory coat, gown, or apron with incorporate sleeves) that is normally worn by hemodialysis personnel. This is particularly important when initiating and terminating dialysis treatment, manipulating access needles or catheters, helping the patient into and out of the station, and cleaning and disinfection of patient care equipment and the dialysis station.
    - Remove and discard the gown in a dedicated container for waste or linen before leaving the dialysis station. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.
  - Gloves
  - Facemask

- Eye protection (e.g., goggles, a disposable face shield that covers the front and sides of the face). Personal glasses and contact lenses are NOT considered adequate eye protection.

Please see discussion below of Expanded Respirator Guidance below for additional information.

**How should facilities ensure appropriate cleaning and disinfection of environmental surfaces, medical devices and equipment?**

- Facilities should continue to follow the infection control requirements related to cleaning and disinfection at 42 CFR §494.30 which include:
  - Ensuring items taken into the dialysis station either be disposed of, dedicated for use only on a single patient, or
  - Cleaned and disinfected per manufacturer’s directions for use before being taken to a common clean area or used on another patient.
- Facilities should implement routine cleaning and disinfection procedures which are appropriate for COVID-19 in healthcare settings which include:
  - Using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product’s label.
  - Using products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.
- Facilities should provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse’s stations, phones, internal radios, etc.).

**When should the dialysis facility consider transferring a patient to an alternative site for treatment?**

- If the facility cannot fully implement the recommended precautions or if the patient’s condition requires care that the dialysis facility is unable to provide, the patient should be transferred to another facility that is capable of implementation. Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.
- While awaiting transfer, patients should wear a facemask and be separated from other patients. If stable, patients can be asked to wait in their vehicles or return home. If that is not possible, then they should be placed in a separate room with the door closed. Contact with patient should be minimized. Appropriate PPE should be used by healthcare personnel when coming within 6 feet of patients with known or suspected COVID-19.

**Are there special considerations for Home Dialysis Patients?**

Dialysis facilities should continue to follow the guidelines as required regarding monthly monitoring of home dialysis patients onsite at the facility. While we want to limit exposure for the home dialysis patients, COVID-19 is particularly aggressive in individuals who are elderly and those with chronic conditions including end-stage renal disease (ESRD). It is important that the home dialysis patients do not miss their onsite appointments to ensure that all dialysis procedures are followed to ensure a safe environment for the patient. Facilities should be vigilant in monitoring any changes in guidelines as new information is available.

### **Will dialysis facilities be cited for not having the appropriate supplies?**

CMS is aware of that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks and ABHR) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHR, we expect staff to practice effective hand washing with soap and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact the local and state public health agency to notify them of the shortage, follow national guidelines for optimizing their current supply, or identify the next best option to care for residents. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the state agency should contact their CMS Location.

### **CDC Resources:**

- Guidance for Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Outpatient Hemodialysis Facilities <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/dialysis.html>
- CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>
- CDC Updates: <https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html>
- CDC FAQ for COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html>
- CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>
- CDC guidance for dialysis safety including infection prevention tools: <https://www.cdc.gov/dialysis/index.html>
- *Strategies for Optimizing the Supply of N95 Respirators:* [https://www.cdc.gov/coronavirus/2019-ncov/hep/respirators-strategy/index.html?CDC\\_AA\\_reVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhep%2Frespirator-supply-strategies.html](https://www.cdc.gov/coronavirus/2019-ncov/hep/respirators-strategy/index.html?CDC_AA_reVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhep%2Frespirator-supply-strategies.html)
- Weekly e-mails regarding COVID-19: [https://tools.cdc.gov/campaignproxyservice/subscriptions.aspx?topic\\_id\\_USCDC\\_2067](https://tools.cdc.gov/campaignproxyservice/subscriptions.aspx?topic_id_USCDC_2067)

### **FDA Resources:**

- Emergency Use Authorizations: <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations>

### **CMS Resources:**

- Appendix H of the State Operations Manual- Guidance to Surveyors: End-Stage Renal Disease Facilities at: [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_h\\_esrd.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_h_esrd.pdf)

- Appendix Z of the State Operations Manual - Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance at:[https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_z\\_emergprep.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_z_emergprep.pdf)
- Dialysis resources on the CMS website including interpretative guidance at:  
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Dialysis>

**Contact:** Questions about this memorandum should be addressed to [QSOG\\_EmergencyPrep@cms.hhs.gov](mailto:QSOG_EmergencyPrep@cms.hhs.gov). Questions about COVID-19 guidance/screening criteria should be addressed to the State Epidemiologist or other responsible state or local public health officials in your state.

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/  
David R. Wright

cc: Survey and Operations Group Management

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-18-IHHA

**DATE:** March 10, 2020

**TO:** State Survey Agency Directors

**FROM:** Director  
Quality, Safety & Oversight Group

**SUBJECT:** Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) in Home Health Agencies (HHAs)

Memorandum Summary

CMS is committed to protecting American patients and residents by ensuring health care facilities have up-to-date information to adequately respond to COVID-19 concerns.

- **Coordination with the Centers for Disease Control and Prevention (CDC) and local public health departments** - We encourage all Home Health Agencies to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>).
- **Home Health Guidance and Actions** - CMS regulations and guidance support Home Health Agencies taking appropriate action to address potential and confirmed COVID cases and mitigate transmission including screening, treatment, and transfer to higher level care (when appropriate). This guidance applies to both Medicare and Medicaid providers.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to the protection of patients in the home care setting from the spread of infectious disease. This memorandum responds to questions we have received and provides important guidance for all Medicare and Medicaid participating Home Health Agencies (HHAs) in addressing the COVID-19 outbreak and minimizing transmission to other individuals.

Guidance

HHAs should monitor the CDC website (see links below) for information and resources and contact their local health department when needed. Also, HHAs should be monitoring the health status of everyone (patients/residents/visitors/staff/etc.) in the homecare setting for signs or

symptoms of COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel, and visitors.

In addition to the overarching regulations and guidance, we have provided the following information (Frequently Asked Questions) about some specific areas related to COVID-19. This guidance is applicable to all Medicare and Medicaid HHA providers.

### **HHA Guidance for Admitting and Treating Patients with known or suspected COVID-19**

#### **Which patients are at risk for severe disease for COVID-19?**

Based upon CDC data, older adults or those with underlying chronic medical conditions may be most at risk for severe outcomes.

#### **How should HHAs screen patients for COVID-19?**

When making a home visit, HHAs should identify patients at risk for having COVID-19 infection before or immediately upon arrival to the home. They should ask patients about the following:

1. International travel within the last 14 days to countries with sustained community transmission. For updated information on affected countries visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>
2. Signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat.
3. In the last 14 days, has had contact with someone with or under investigation for COVID-19, or are ill with respiratory illness.
4. Residing in a community where community-based spread of COVID-19 is occurring.

For ill patients, implement source control measures (i.e., placing a facemask over the patient's nose and mouth if that has not already been done).

Inform the HHA clinical manager, local and state public health authorities about the presence of a person under investigation (PUI) for COVID-19. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC COVID-19 website.

CMS regulations requires that home health agencies provide the types of services, supplies and equipment required by the individualized plan of care. HHA's are normally expected to provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS). State and Federal surveyors should not cite home health agencies for not providing certain supplies (e.g., personal protective equipment (PPE) such as gowns, respirators, surgical masks and alcohol-based hand rubs (ABHR)) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect providers/suppliers to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible.

#### **How should HHAs monitor or restrict home visits for health care staff?**

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:

- Immediately stop work, put on a facemask, and self-isolate at home;
  - Inform the HHA clinical manager of information on individuals, equipment, and locations the person came in contact with; and
  - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>)

HHAs should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals:  
<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>

**Do all patients with known or suspected COVID-19 infection require hospitalization?**

Patients may not require hospitalization and can be managed at home if they are able to comply with monitoring requests. More information is available here:  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html>

**What are the considerations for determining when patients *confirmed* with COVID-19 are safe to be treated at home?**

Although COVID-19 patients with mild symptoms may be managed at home, the decision to remain in the home should consider the patient’s ability to adhere to isolation recommendations, as well as the potential risk of secondary transmission to household members with immunocompromising conditions. More information is available here:  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html>

**When should patients *confirmed* with COVID-19 who are receiving HHA services be considered for transfer to a hospital?**

Initially, symptoms maybe mild and not require transfer to a hospital as long as the individual with support of the HHA can follow the infection prevention and control practices recommended by CDC. (<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>)

The patient may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, emergency medical services and the receiving hospital should be alerted to the patient’s diagnosis, and precautions to be taken including placing a facemask on the patient during transfer. If the patient does not require hospitalization they can be discharged back to home (in consultation with state or local public health authorities) if deemed medically and environmentally appropriate. Pending transfer or discharge, place a facemask on the patient and isolate him/her in a room with the door closed.

**What are the implications of the Medicare HHA Discharge Planning Regulations for Patients with COVID-19?**

Medicare’s Discharge Planning Regulations (which were updated in November 2019)

requires that HHA assess the patient's needs for post-IHA services, and the availability of such services. When a patient is discharged, all necessary medical information (including communicable diseases) must be provided to any other service provider. For COVID-19 patients, this must be communicated to the receiving service provider prior to the discharge/transfer and to the healthcare transport personnel.

**What are recommended infection prevention and control practices, including considerations for family member exposure, when evaluating and caring for patients with known or suspected COVID-19?**

The CDC advises the patient to stay home except to get medical care, separate yourself from other people and animals in the home as much as possible (in a separate room with the door closed), call ahead before visiting your doctor, and wear a facemask in the presence of others when out of the patient room.

For everyone in the home, CDC advises covering coughs and sneezes followed by hand washing or using an alcohol-based hand rub, not sharing personal items (dishes, eating utensils, bedding) with individuals with known or suspected COVID-19, cleaning all "high-touch" surfaces daily, and monitoring for symptoms. We would ask that HHA's share additional information with families. Please see <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html> and <https://www.cdc.gov/coronavirus/2019-ncov/community/home/index.html>.

Detailed infection prevention and control recommendations are available in the CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons under Investigation for COVID-19 in Healthcare Settings: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

**Are there specific considerations for patients requiring therapeutic interventions?**

Patients with known or suspected COVID-19 should continue to receive the intervention appropriate for the severity of their illness and overall clinical condition. Because some procedures create high risks for transmission (close patient contact during care) precautions include: 1) HCP should wear all recommended PPE, 2) the number of HCP present should be limited to essential personnel, and 3) any supplies brought into, used, and removed from the home must be cleaned and disinfected in accordance with environmental infection control guidelines.

**What Personal Protective Equipment should home care staff routinely use when visiting the home of a patient suspected of COVID-19 exposure or confirmed exposure?**

If care to patients with respiratory or gastrointestinal symptoms who are confirmed or presumed to be COVID-19 positive is anticipated, then HHAs should refer to the Interim Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings: <https://www.cdc.gov/coronavirus/2019-ncov/php/guidance-evaluating-pui.html>

Hand hygiene should be performed before putting on and after removing PPE using alcohol-based hand sanitizer that contains 60 to 95% alcohol.

PPE should ideally be put on outside of the home prior to entry into the home. If unable to put on all PPE outside of the home, it is still preferred that face protection (i.e., respirator and eye protection) be put on before entering the home. Alert persons within the home that the public health personnel will be entering the home and ask them to move to a different room, if possible, or keep a 6-foot distance in the same room. Once the entry area is clear, enter the home and put on a gown and gloves.

Ask person being tested if an external trash can is present at the home, or if one can be left outside for the disposal of PPE. PPE should ideally be removed outside of the home and discarded by placing in external trash can before departing location. PPE should not be taken from the home of the person being tested in public health personnel's vehicle.

If unable to remove all PPE outside of the home, it is still preferred that face protection (i.e., respirator and eye protection) be removed after exiting the home. If gown and gloves must be removed in the home, ask persons within the home to move to a different room, if possible, or keep a 6-foot distance in the same room. Once the entry area is clear, remove gown and gloves and exit the home. Once outside the home, perform hand hygiene with alcohol-based hand sanitizer that contains 60 to 95% alcohol, remove face protection and discard PPE by placing in external trash can before departing location. Perform hand hygiene again.

#### **When is it safe to discontinue Transmission-based Precautions for home care patients with COVID-19?**

The decision to discontinue Transmission-Based Precautions for home care patients with COVID-19 should be made in consultation with clinicians, infection prevention and control specialists, and public health officials. This decision should consider disease severity, illness signs and symptoms, and results of laboratory testing for COVID-19 in respiratory specimens. For more details, please refer to: <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/disposition-in-home-patients.html>.

Considerations to discontinue in-home isolation include all of the following:

- Resolution of fever, without use of antipyretic medication
- Improvement in illness signs and symptoms
- Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive sets of paired nasopharyngeal and throat swabs specimens collected  $\geq 24$  hours apart\* (total of four negative specimens—two nasopharyngeal and two throat). See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation \(PUIs\) for 2019 Novel Coronavirus \(2019-nCoV\)](#) for specimen collection guidance.

\*Initial guidance is based upon limited information and is subject to change as more information becomes available. In persons with a persistent productive cough, SARS-CoV-2-RNA might be detected for longer periods in sputum specimens than in upper respiratory tract (nasopharyngeal swab and throat swab) specimens.

## **Protocols for Coordination and Investigation of Home Health Agencies with Actual or Suspected COVID-19 Cases**

During a home health agency survey, when a COVID-19 confirmed case or suspected case (including PUI) is identified, the surveyors will confirm that the agency has reported the case to public health officials as required by state law and will work with the agency to review infection prevention and education practices. Confirm that the HHA has the most recent information provided by the CDC.

- The State should notify the appropriate CMS Regional Office of the HHA who has been identified as providing services to a person with confirmed or suspected COVID-19 (including persons under investigation) who do not need to be hospitalized;
- The State should notify the appropriate CMS Regional Office of the HHA who has been identified as providing services to a person with confirmed COVID-19 who were hospitalized and determined to be medically stable to go home.

CMS is aware of that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite providers/suppliers for not having certain supplies (e.g., personal protective equipment (PPE) such as gowns, respirators, surgical masks and alcohol-based hand rubs (ABHR)) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect providers/suppliers to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHR, we expect staff to practice effective hand washing with soap and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact the appropriate local authorities notifying them of the shortage, follow national guidelines for optimizing their current supply, or identify the next best option to care for patients. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the state agency should contact the CMS Regional Office.

### **Important CDC Resources:**

#### **CDC Resources for Health Care Facilities and Home and Community Based Settings:**

- CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>
- CDC FAQ for COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html>
- CDC Guidance for Preventing Spread in Home and Community Settings <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html>
- Strategies for Optimizing the Supply of N95 Respirators: [https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html?CDC\\_AA\\_reftVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Frespirator-supply-strategies.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html?CDC_AA_reftVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Frespirator-supply-strategies.html)

- CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>
- Resources for Households <https://www.cdc.gov/coronavirus/2019-ncov/community/home/index.html>

**FDA Resources:**

Emergency Use Authorizations: <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations>

**CMS Resources:**

Home Health Agency Infection Control and Prevention regulations and guidance: 42 CFR 484.70, Infection Prevention and Control, Appendix B of the State Operations Manual, Infection Prevention and Control. [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_b\\_lha.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_lha.pdf)

**CDC Updates:**

<https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html>

Sign up for the newsletter to receive weekly emails about the coronavirus disease 2019 (COVID-19) [https://tools.cdc.gov/campaignproxyservice/subscriptions.aspx?topic\\_id=USCDC\\_2067](https://tools.cdc.gov/campaignproxyservice/subscriptions.aspx?topic_id=USCDC_2067)

**Contact:** Questions about this memorandum should be addressed to [OSOG\\_EmergencyPrep@cms.hhs.gov](mailto:OSOG_EmergencyPrep@cms.hhs.gov). Questions about COVID-19 guidance/screening criteria should be addressed to the State Epidemiologist or other responsible state or local public health officials in your state.

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

*/s/*  
David R. Wright

cc: Survey and Operations Group Management



**Center for Clinical Standards and Quality/Survey & Certification Group**

Ref: QSO-20-38-NH

**DATE:** August 26, 2020

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements and Revised COVID-19 Focused Survey Tool

**Memorandum Summary**

- CMS is committed to taking critical steps to ensure America's healthcare facilities continue to respond effectively to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- On August 25, 2020, CMS published an interim final rule with comment period (IFC). This rule establishes **Long-Term Care (LTC) Facility Testing Requirements for Staff and Residents**. Specifically, facilities are required to test residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19 based on parameters set forth by the HHS Secretary. This memorandum provides guidance for facilities to meet the new requirements.
- **Revised COVID-19 Focused Survey Tool** - To assess compliance with the new testing requirements, CMS has revised the survey tool for surveyors. We are also adding to the survey process the assessment of compliance with the requirements for facilities to designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility's infection prevention and control program (IPCP) at 42 CFR § 483.80(b). In addition, we are making a number of revisions to the survey tool to reflect other COVID-19 guidance updates.

On August 25, 2020, CMS published an interim final rule with comment period (IFC), CMS-3401-IFC, entitled "Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments of 1988 (CLIA), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency".

CMS's recommendation below to test with authorized nucleic acid or antigen detection assays is an important addition to other infection prevention and control (IPC) recommendations aimed at preventing COVID-19 from entering nursing homes, detecting cases quickly, and stopping transmission. Swift identification of confirmed COVID-19 cases allows the facility to take immediate action to remove exposure risks to nursing home residents and staff. CMS has added



42 CFR § 483.80(h) which requires that the facility test all residents and staff for COVID-19. Guidance related to the requirements is located below. Noncompliance related to this new requirement will be cited at new tag F886.

### **§ 483.80 Infection control**

\* \* \* \* \*

**§ 483.80(h) COVID-19 Testing.** The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:

- (1) Conduct testing based on parameters set forth by the Secretary, including but not limited to:**
  - (i) Testing frequency;**
  - (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;**
  - (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;**
  - (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;**
  - (v) The response time for test results; and**
  - (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.**
- (2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;**
- (3) For each instance of testing:**
  - (i) Document that testing was completed and the results of each staff test; and**
  - (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.**
- (4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.**
- (5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.**
- (6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.**

## **GUIDANCE FOR F886**

### **Testing of Nursing Home Staff and Residents**

To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary.

Facilities can meet the testing requirements through the use of rapid point-of-care (POC) diagnostic testing devices or through an arrangement with an offsite laboratory. POC Testing is diagnostic testing that is performed at or near the site of resident care. For a facility to conduct these tests with their own staff and equipment (including POC devices provided by the Department of Health and Human Services), the facility must have a CLIA Certificate of Waiver. Information on obtaining a CLIA Certificate of Waiver can be found [here](#).

Facilities without the ability to conduct COVID-19 POC testing should have arrangements with a laboratory to conduct tests to meet these requirements. Laboratories that can quickly process large numbers of tests with rapid reporting of results (e.g., within 48 hours) should be selected to rapidly inform infection prevention initiatives to prevent and limit transmission.

“**Facility staff**” includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility’s nurse aide training programs or from affiliated academic institutions. For the purpose of testing “individuals providing services under arrangement and volunteers,” facilities should prioritize those individuals who are regularly in the facility (e.g., weekly) and have contact with residents or staff. We note that the facility may have a provision under its arrangement with a vendor or volunteer that requires them to be tested from another source (e.g., their employer or on their own). However, the facility is still required to obtain documentation that the required testing was completed during the timeframe that corresponds to the facility’s testing frequency, as described in Table 2 below.

Regardless of the frequency of testing being performed or the facility’s COVID-19 status, the facility should continue to screen all staff (each shift), each resident (daily), and all persons entering the facility, such as vendors, volunteers, and visitors, for signs and symptoms of COVID-19.

When prioritizing individuals to be tested, facilities should prioritize individuals with signs and symptoms of COVID-19 first, then perform testing triggered by an outbreak (as specified below).

**Table 1: Testing Summary**

<b>Testing Trigger</b>	<b>Staff</b>	<b>Residents</b>
Symptomatic individual identified	Staff with signs and symptoms must be tested	Residents with signs and symptoms must be tested
Outbreak (Any new case arises in facility)	Test all staff that previously tested negative until no new cases are identified*	Test all residents that previously tested negative until no new cases are identified*
Routine testing	According to Table 2 below	Not recommended, unless the resident leaves the facility routinely.

\*For outbreak testing, all staff and residents should be tested, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of

COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. For more information, please review the section below titled, “Testing of Staff and Residents in Response to an Outbreak.”

#### **Testing of Staff and Residents with COVID-19 Symptoms or Signs**

Staff with symptoms or signs of COVID-19 must be tested and are expected to be restricted from the facility pending the results of COVID-19 testing. If COVID-19 is confirmed, staff should follow Centers for Disease Control and Prevention (CDC) guidelines “[Criteria for Return to Work for Healthcare Personnel with SARS-CoV2 Infection.](#)” Staff who do not test positive for COVID-19 but have symptoms should follow facility policies to determine when they can return to work.

Residents who have signs or symptoms of COVID-19 must be tested. While test results are pending, residents with signs or symptoms should be placed on transmission-based precautions (TBP) in accordance with [CDC guidance](#). Once test results are obtained, the facility must take the appropriate actions based on the results.

Note: Concerns related to initiating and/or maintaining TBP should be investigated under F880, Infection Control.

#### **Testing of Staff and Residents in Response to an Outbreak**

An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any [nursing home-onset](#) COVID-19 infection in a resident. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. A resident who is admitted to the facility with COVID-19 does not constitute a facility outbreak.

Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents should be tested, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. See CDC guidance “Testing Guidelines for Nursing Homes” section [Non-diagnostic testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2.](#)

For individuals who test positive for COVID-19, repeat testing is not recommended. A symptom-based strategy is intended to replace the need for repeated testing. Facilities should follow the CDC guidance [Test-Based Strategy for Discontinuing Transmission-Based Precautions](#) for residents and [Criteria for Return to Work for Healthcare Personnel with SARS-CoV2 Infection.](#)

#### **Routine Testing of Staff**

Routine testing should be based on the extent of the virus in the community, therefore facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency. Reports of COVID-19 county-level positivity rates will be available on the following website by August 28, 2020 (see section titled, “COVID-19 Testing”): <https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg>

**Table 2: Routine Testing Intervals Vary by Community COVID-19 Activity Level**

<b>Community COVID-19 Activity</b>	<b>County Positivity Rate in the past week</b>	<b>Minimum Testing Frequency</b>
<b>Low</b>	<b>&lt;5%</b>	<b>Once a month</b>
<b>Medium</b>	<b>5% - 10%</b>	<b>Once a week*</b>
<b>High</b>	<b>&gt;10%</b>	<b>Twice a week*</b>

\*This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.

If the 48-hour turn-around time cannot be met due to community testing supply shortages, limited access or inability of laboratories to process tests within 48 hours, the facility should have documentation of its efforts to obtain quick turnaround test results with the identified laboratory or laboratories and contact with the local and state health departments.

The facility should begin testing all staff at the frequency prescribed in the Routine Testing table based on the county positivity rate reported in the past week. Facilities should monitor their county positivity rate every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table above.

- If the county positivity rate increases to a higher level of activity, the facility should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity are met.
- If the county positivity rate decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the county positivity rate has remained at the lower activity level for at least two weeks before reducing testing frequency.

The guidance above represents the minimum testing expected. Facilities may consider other factors, such as the positivity rate in an adjacent (i.e., neighboring) county to test at a frequency that is higher than required. For example, if a facility in a county with low a positivity rate has many staff that live in a county with a medium positivity rate, the facility should consider testing based on the higher positivity rate (in scenario described, weekly staff testing would be indicated).

State and local officials may also direct facilities to monitor other factors that increase the risk for COVID-19 transmission, such as rates of Emergency Department visits of individuals with COVID-19-like symptoms. Facilities should consult with state and local officials on these factors, and the actions that should be taken to reduce the spread of the virus. <https://www.cdc.gov/covid-data-tracker/index.html#ed-visits>.

NOTE: Routine testing of asymptomatic residents is not recommended unless prompted by a change in circumstances, such as the identification of a confirmed COVID-19 case in the facility. Facilities may consider testing asymptomatic residents who leave the facility frequently, such as for dialysis or chemotherapy. Facilities should inform resident transportation services (such as non-emergency medical transportation) and receiving healthcare providers (such as hospitals) regarding a resident's COVID-19 status to ensure appropriate infection control precautions are followed.

Routine communication between the nursing home and other entities about the resident's status should ideally occur prior to the resident leaving the nursing home for treatment. Coordination between the nursing home and the other healthcare entity is vital to ensure healthcare staff are informed of the most up to date information relating to the resident's health status, including COVID-19 status, and to allow for proper planning of care and operations. Additionally, facilities should maintain communications with the local ambulance and other contracted providers that transport residents between facilities, to ensure appropriate infection control precautions are followed as described by the CDC.

### **Refusal of Testing**

Facilities must have procedures in place to address staff who refuse testing. Procedures should ensure that staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met. If outbreak testing has been triggered and a staff member refuses testing, the staff member should be restricted from the building until the procedures for outbreak testing have been completed. The facility should follow its occupational health and local jurisdiction policies with respect to any asymptomatic staff who refuse routine testing.

Residents (or resident representatives) may exercise their right to decline COVID-19 testing in accordance with the requirements under 42 CFR § 483.10(c)(6). In discussing testing with residents, staff should use person-centered approaches when explaining the importance of testing for COVID-19. Facilities must have procedures in place to address residents who refuse testing. Procedures should ensure that residents who have signs or symptoms of COVID-19 and refuse testing are placed on TBP until the criteria for discontinuing TBP have been met. If outbreak testing has been triggered and an asymptomatic resident refuses testing, the facility should be extremely vigilant, such as through additional monitoring, to ensure the resident maintains appropriate distance from other residents, wears a face covering, and practices effective hand hygiene until the procedures for outbreak testing have been completed.

Clinical discussions about testing may include alternative specimen collection sources that may be more acceptable to residents than nasopharyngeal swabs (e.g., anterior nares). Providing information about the method of testing and reason for pursuing testing may facilitate discussions with residents or resident representatives.

If a resident has symptoms consistent with COVID-19 or has been exposed to COVID-19, or if there is a facility outbreak and the resident declines testing, he or she should be placed on or remain on TBP until he or she meets the symptom-based criteria for discontinuation.

### **Other Testing Considerations**

In keeping with current CDC recommendations staff and residents who have recovered from COVID-19 and are asymptomatic do not need to be retested for COVID-19 within 3 months after symptom onset. Until more is known, testing should be encouraged again (e.g., in response to an exposure) 3 months after the date of symptom onset with the prior infection. Facilities should continue to monitor the CDC webpages and FAQs for the latest information. The facility should consult with infectious diseases specialists and public health authorities to review all available information (e.g., medical history, time from initial positive test, Reverse Transcription-Polymerase Chain Reaction Cycle Threshold (RT-PCR Ct) values, and presence of COVID-19 signs or symptoms). Individuals who are determined to be potentially infectious

should undergo evaluation and remain isolated until they meet criteria for discontinuation of isolation or discontinuation of transmission-based precautions, depending on their circumstances.

For residents or staff who test positive, facilities should contact the appropriate state or local entity for contact tracing.

While not required, facilities may test residents' visitors to help facilitate visitation while also preventing the spread of COVID-19. Facilities should prioritize resident and staff testing and have adequate testing supplies to meet required testing, prior to testing resident visitors.

### **Conducting Testing**

In accordance with 42 CFR § 483.50(a)(2)(i), the facility must obtain an order from a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with State law, including scope of practice laws to provide or obtain laboratory services for a resident, which includes COVID-19 testing (see F773). This may be accomplished through the use of physician approved policies (e.g., standing orders), or other means as specified by scope of practice laws and facility policy.

NOTE: Concerns related to orders for laboratory and/or POC testing should be investigated under F773.

Rapid POC Testing devices are prescription use tests under the Emergency Use Authorization and must be ordered by a healthcare professional licensed under the applicable state law or a pharmacist under HHS guidance. Accordingly, the facility must have an order from a healthcare professional or pharmacist, as previously described, to perform a rapid POC COVID-19 test on an individual.

Facilities must conduct testing according to nationally recognized guidelines, outlined by the Centers for Disease Control and Prevention (CDC). This would include the following guidelines:

- Preparing for COVID-19 in Nursing Homes: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>.
- Testing Guidelines for Nursing Homes: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>.
- Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-facility-wide-testing.html>.
- Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html>.

A diagnostic test shows if a patient has an active coronavirus infection. As of the date of this guidance, there are two types of diagnostic tests which detect the active virus – molecular tests, such as RT-PCR tests, that detect the virus's genetic material, and antigen tests that detect specific proteins on the surface of the virus. An antibody test looks for antibodies that are made by the immune system in response to a threat, such as a specific virus. An antibody test does not identify an active coronavirus infection; therefore, conducting an antibody test on a staff or resident would not meet the requirements under this regulation.

Frequently asked questions related to the use of these testing devices in high-risk congregate

settings such as nursing homes can be found [here](#). In addition, when testing residents, a facility's selection of a test should be person-centered.

Collecting and handling specimens correctly and safely is imperative to ensure the accuracy of test results and prevent any unnecessary exposures. The specimen should be collected and, if necessary, stored in accordance with the manufacturer's instructions for use for the test and CDC guidelines.

During specimen collection, facilities must maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens.

The CDC has provided guidance on proper specimen collection:

- See section "Recommendations for conducting swabbing" under CDC's "Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes": <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-facility-wide-testing.html>.
- Influenza Specimen Collection: <https://www.cdc.gov/flu/pdf/professionals/flu-specimen-collection-poster.pdf>.
- Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19): (<https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html>).
- CDC's Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Coronavirus Disease 2019 (COVID-19): <https://www.cdc.gov/coronavirus/2019-ncov/lab/lab-biosafety-guidelines.html#decentralized>.
- Guidelines for Safe Work Practices in Human and Animal Medical Diagnostic Laboratories: <https://www.cdc.gov/coronavirus/2019-ncov/lab/lab-biosafety-guidelines.html>.

For additional considerations for antigen testing, see CDC's [Interim Guidance for Rapid Antigen Testing for SARS-CoV-2](#).

As a reminder, per 42 CFR § 483.50(a), the facility must provide or obtain laboratory services to meet the needs of its residents. If a facility provides its own laboratory services or performs any laboratory tests directly (e.g., SARS-CoV-2 point-of-care test) the provisions of 42 CFR Part 493 apply and the facility must have a current CLIA certificate appropriate for the level of testing performed within the facility. Surveyors should only verify that the facility has a current CLIA certificate and not attempt to determine compliance with the requirements in 42 CFR Part 493.

### **Reporting Test Results**

Facilities conducting tests under a CLIA certificate of waiver are subject to regulations that require laboratories to report data for all testing completed, for each individual tested. For additional information on reporting requirements see:

- [Frequently Asked Questions: COVID-19 Testing at Skilled Nursing Facilities/Nursing Homes](#)

- CMS memorandum: [Interim Final Rule \(IFC\), CMS-3401-IFC, Updating Requirements for Reporting of SARS-CoV-2 Test Results by Clinical Laboratory Improvement Amendments of 1988 \(CLIA\) Laboratories, and Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency](#)

Surveyors should report concerns related to CLIA certificates or laboratory reporting requirements to the CMS Division of Clinical Laboratory Improvement and Quality at [LabExcellence@cms.hhs.gov](mailto:LabExcellence@cms.hhs.gov). When reporting concerns include the CLIA number; name and address of laboratory (facility); number of days that results were not reported, if known; and number of results not reported, if known.

In addition to reporting in accordance with CLIA requirements, facilities must continue to report COVID-19 information to the CDC's National Healthcare Safety Network (NHSN), in accordance with 42 CFR § 483.80(g)(1)–(2). See “Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes,” CMS Memorandum [QSO-20-29-NH \(May 6, 2020\)](#).

NOTE: Concerns related to informing residents, their representatives and families of new or suspected cases of COVID-19 should be investigated under F885.

NOTE: Concerns related to the reporting to state and local public health authority of communicable diseases and outbreaks, including for purposes such as contact tracing, should be investigated under F880.

### **Documentation of Testing**

Facilities must demonstrate compliance with the testing requirements. To do so, facilities should do the following:

- For symptomatic residents and staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results.
- Upon identification of a new COVID-19 case in the facility (i.e., outbreak), document the date the case was identified, the date that all other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests. All residents and staff that tested negative are expected to be retested until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result (see section Testing of Staff and Residents in response to an outbreak above).
- For staff routine testing, document the facility's county positivity rate, the corresponding testing frequency indicated (e.g., every other week), and the date each positivity rate was collected. Also, document the date(s) that testing was performed for all staff, and the results of each test.
- Document the facility's procedures for addressing residents and staff that refuse testing or are unable to be tested, and document any staff or residents who refused or were unable to be tested and how the facility addressed those cases.
- When necessary, such as in emergencies due to testing supply shortages, document that the facility contacted state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.

Facilities may document the conducting of tests in a variety of ways, such as a log of county positivity rates, schedules of completed testing, and/or staff and resident records. However, the results of tests must be done in accordance with standards for protected health information. For residents, the facility must document testing results in the medical record. For staff, including individuals providing services under arrangement and volunteers, the facility must document testing results in a secure manner consistent with requirements specified in 483.80(h)(3).

### **Surveying for Compliance**

Compliance will be assessed through the following process using the COVID-19 Focused Survey for Nursing Homes:

1. Surveyors will ask for the facility's documentation noted in the "Documentation of Testing" section above, and review the documentation for compliance.
2. Surveyors will also review records of those residents and staff selected as a sample as part of the survey process.
3. If possible, surveyors should observe how the facility conducts testing in real-time. In this process, surveyors will assess if the facility is conducting testing and specimen collection in a manner that is consistent with current standards of practice for conducting COVID-19 tests, such as ensuring PPE is used correctly to prevent the transmission of the virus. If observation is not possible, surveyors should interview an individual responsible for testing and inquire on how testing is conducted (e.g., "what are the steps taken to conduct each test?").
4. If the facility has a shortage of testing supplies, or cannot obtain test results within 48 hours, the surveyor should ask for documentation that the facility contacted state and local health departments to assist with these issues.

Facilities that do not comply with the testing requirements in § 483.80(h) will be cited for noncompliance at F886. Additionally, enforcement remedies (such as civil money penalties) will be imposed based on the resident outcome (i.e., the scope and severity of the noncompliance), in accordance with Chapter 7 of the State Operations Manual.

If the facility has documentation that demonstrates their attempts to perform and/or obtain testing in accordance with these guidelines (e.g., timely contacting state officials, multiple attempts to identify a laboratory that can provide testing results within 48 hours), surveyors should not cite the facility for noncompliance. Surveyors should also inform the state or local health authority of the facility's lack of resources.

CMS is also continuing to assess automated methods for determining compliance with the testing requirements, which may augment the assessment of compliance through onsite surveys.

### **Additional Resource Links:**

- Clinical Questions about COVID-19: Questions and Answers-Testing in Nursing Homes <https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Testing-in-Nursing-Homes>
- Nursing Home Reopening Recommendations for State and Local Officials <https://www.cms.gov/files/document/qso-20-30-nh.pdf-0>
- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>

**COVID-19 Focused Survey for Nursing Homes**

CMS is revising the COVID-19 Focused Survey for Nursing Homes tool to reflect the new testing requirements implemented in the IFC, as well as other updates to help ensure an effective assessment of the facility's compliance, such as selecting a number of residents as a sample to review the facility's application of the standards on that sample, and that a facility is implementing the appropriate infection prevention standards (e.g., transmission-based precautions, face coverings, etc.). We are also revising the survey process to include the assessment of compliance with the requirements for facilities to designate one or more individuals as the infection preventionist(s) (IPs) who are responsible for the facility's infection prevention and control program at 42 CFR § 483.80(b). Noncompliance related to this requirement will be cited at tag F882.

**Contact:** Questions related to the nursing home testing requirement may be submitted to: [DNH\\_TriageTeam@cms.hhs.gov](mailto:DNH_TriageTeam@cms.hhs.gov).

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers and the State Agency/CMS Branch Location training coordinators immediately.

/s/  
David R. Wright

Attachments:

COVID-19 Focused Survey for Nursing Homes

## COVID-19 Focused Survey for Nursing Homes

### Infection Control

This survey tool must be used to investigate compliance at F880, **F882**, F884 (CMS Federal surveyors only), F885, **F886**, and E0024. Surveyors must determine whether the facility is implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19 and other communicable diseases and infections. Entry and screening procedures as well as resident care and guidance has varied over the progression of COVID-19 transmission in facilities. Facilities are expected to be in compliance with CMS requirements and surveyors will use guidance that is in effect at the time of the survey. Refer to QSO memos released at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions>.

This survey tool provides a focused review of the critical elements associated with the transmission of COVID-19, will help surveyors to prioritize survey activities while onsite, and identifies those survey activities which can be accomplished offsite. These efficiencies will decrease the potential for transmission of COVID-19, as well as lessen disruptions to the facility and minimize exposure of the surveyor. Surveyors should be mindful to ensure their activities do not interfere with the active treatment or prevention of transmission of COVID-19.

If citing for noncompliance related to COVID-19, the surveyor(s) must include the following language at the beginning of the Deficient Practice Statement or other place determined appropriate on the Form CMS-2567: “Based on [observations/interviews/record review], the facility failed to [properly prevent and/or contain – or other appropriate statement] **COVID-19**.”

If surveyors see concerns related to compliance with other requirements, they should investigate them in accordance with the existing guidance in Appendix PP of the State Operations Manual and related survey instructions. Surveyors may also need to consider investigating concerns related to Emergency Preparedness in accordance with the guidance in Appendix Z of the State Operations Manual (e.g., for emergency staffing).

For the purpose of this survey tool, “staff” includes employees, consultants, contractors, volunteers, and others who provide care and services to residents on behalf of the facility. The Infection Prevention and Control Program (IPCP) must be facility-wide and include all departments and contracted services.

Note: It is imperative that surveyors refer to the most recent information for COVID-19 testing parameters and frequency set forth by the Secretary **described in the guidance for F886**. **County-level data are available on the CDC website:** <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/county-map.html>.

**Critical Element #8 is only for consideration by CMS Federal Survey staff. Information to determine the facility’s compliance at F884 is only reported to each of the 10 CMS locations.**

## COVID-19 Focused Survey for Nursing Homes

### Surveyor(s) reviews for:

- The overall effectiveness of the Infection Prevention and Control Program (IPCP) including IPCP policies and procedures;
- Standard and Transmission-Based Precautions (review care of a resident under observation, suspected of, or confirmed to have COVID-19 infection);
- Quality of resident care practices, including those under observation, suspected of, and confirmed to have COVID-19 infection, if applicable;
- The surveillance and testing process;
- Visitor entry and facility screening practices;
- Education, monitoring, and screening practices of staff;
- Actions taken to prevent transmission, such as cohorting and managing care for residents suspected of having or confirmed to have COVID-19;
- Facility policies and procedures to address staffing issues during emergencies, such as transmission of COVID-19;
- How the facility informs residents, their representatives, and families of suspected or confirmed COVID-19 cases in the facility; and
- The infection preventionist role.

*The survey team will select a random sample of three residents, and if not already sampled, add one additional resident who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19, for purposes of determining compliance.*

*The survey team will select a random sample of three staff, and if not already sampled, add one additional staff who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19, for purposes of determining compliance.*

### 1. Standard and Transmission-Based Precautions (TBPs)

CMS is aware that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of PPE (e.g., due to supplier shortage, which may be a regional or national issue), the facility should contact their healthcare coalition for assistance (<https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx>), follow national and/or local guidelines for optimizing their current supply, or identify the next best option to care for residents. Among other practices, optimizing their current supply may mean prioritizing use of gowns based on risk of exposure to infectious organisms, blood or body fluids, splashes or sprays, high contact procedures, or aerosol generating procedures (AGPs), as well as possibly extending use of PPE (follow national and/or local guidelines). Current CDC

## COVID-19 Focused Survey for Nursing Homes

guidance for healthcare professionals is located at: <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html> and healthcare facilities is located at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/us-healthcare-facilities.html>. Guidance on strategies for optimizing PPE supply is located at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the State Agency should contact the CMS Regional Location.

### General Standard Precautions:

- Are staff performing the following appropriately:
  - Respiratory hygiene/cough etiquette,
  - Environmental cleaning and disinfection, and
  - Reprocessing of reusable resident medical equipment (e.g., cleaning and disinfection of glucometers per device and disinfectant manufacturer's instructions for use)?

### Hand Hygiene:

- Are staff performing hand hygiene when indicated?
- If alcohol-based hand rub (ABHR) is available, is it readily accessible and preferentially used by staff for hand hygiene?
- If there are shortages of ABHR, are staff performing hand hygiene using soap and water instead?
- Are staff washing hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids)?
- Do staff perform hand hygiene (even if gloves are used) in the following situations:
  - Before and after contact with the resident;
  - After contact with blood, body fluids, or visibly contaminated surfaces;
  - After contact with objects and surfaces in the resident's environment;
  - After removing personal protective equipment (e.g., gloves, gown, facemask); and
  - Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, and/or dressing care)?
- When being assisted by staff, is resident hand hygiene performed after toileting and before meals? *How are residents reminded to perform hand hygiene?*
- Interview appropriate staff to determine if hand hygiene supplies (e.g., ABHR, soap, paper towels) are readily available and who they contact for replacement supplies.

## COVID-19 Focused Survey for Nursing Homes

### Personal Protective Equipment (PPE):

- Determine if staff appropriately use PPE including, but not limited to, the following:
- Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
  - Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin;
  - Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care; and
  - An isolation gown, *eye protection (e.g. goggles or face shield), and an N95 or equivalent or higher-level respirator are worn for direct resident contact if the resident has uncontained secretions or excretions including splashes or sprays.*
- Is PPE appropriately removed and discarded after resident care, prior to leaving room (except in the case of extended use of PPE per national/local recommendations), followed by hand hygiene?
- If PPE use is extended/reused, is it done according to national and/or local guidelines? If it is reused, is it cleaned/decontaminated/maintained after and/or between uses?
- Interview appropriate staff to determine if PPE is available, accessible, and used by staff.
- Are there sufficient PPE supplies available to follow infection prevention and control guidelines? In the event of PPE shortages, what actions is the facility taking to address this issue?
  - Do staff know how to obtain PPE supplies before providing care?
  - Do they know who to contact for replacement supplies?
- Are all staff wearing a facemask (e.g., a cloth face covering can be used by staff where PPE is not indicated, such as administrative staff who are not at risk of coming in contact with infectious materials)?*
- When COVID-19 is present in the facility, are staff wearing an N95 or equivalent or higher-level respirator, instead of a facemask, for aerosol generating procedures?*

### Source Control:

- Are residents, visitors, and others at the facility donning a cloth face covering or facemask while in the facility or while around others outside?*

### Transmission-Based Precautions (Note: PPE use is based on availability and latest CDC guidance. See note on Pages 1-2):

- Determine if appropriate Transmission-Based Precautions are implemented:
- For a resident on Contact Precautions: staff don gloves and isolation gown before contact with the resident and/or his/her environment;
  - For a resident on Droplet Precautions: staff don a facemask within six feet of a resident;
  - For a resident on Airborne Precautions: staff don an N95 or higher-level respirator prior to room entry of a resident;

## COVID-19 Focused Survey for Nursing Homes

- For a resident with an undiagnosed respiratory infection: staff follow Standard, Contact, and Droplet Precautions (i.e., facemask, gloves, isolation gown) with eye protection when caring for a resident unless the suspected diagnosis requires Airborne Precautions (e.g., tuberculosis);
- For a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available. A facemask is an acceptable alternative if a respirator is not available. When COVID-19 is identified in the facility, staff wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability).
  - Some procedures performed on residents with known or suspected COVID-19 could generate infectious aerosols (i.e., aerosol-generating procedures (AGPs)). In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously. If performed, the following should occur:
    - Staff in the room should wear an N95 or higher-level respirator, eye protection, gloves, and an isolation gown.
    - The number of staff present during the procedure should be limited to only those essential for resident care and procedure support.
    - AGPs should ideally take place in an airborne infection isolation room (AIIR). If an AIIR is not available and the procedure is medically necessary, then it should take place in a private room with the door closed.
    - Clean and disinfect the room surfaces with an appropriate disinfectant. Use disinfectants on List N of the EPA website that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2 or other national recommendations.
  - Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant for healthcare setting (*effective against the identified organism if known*) prior to use on another resident;
  - Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare setting (effective against the organism identified if known) at least daily and when visibly soiled; and
  - Is signage on the use of specific PPE (for staff) posted in appropriate locations in the facility (e.g., outside of a resident's room, wing, or facility-wide)?
- Interview appropriate staff to determine if they are aware of processes/protocols for Transmission-Based Precautions and how staff is monitored for compliance.
- Observe staff to determine if they use appropriate infection control precautions when moving between resident rooms, units and other areas of the facility.
- If concerns are identified, expand the sample to include more residents on Transmission-Based Precautions.

## COVID-19 Focused Survey for Nursing Homes

1. Did staff implement appropriate Standard (e.g., hand hygiene, appropriate use of PPE, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment) and Transmission-Based Precautions (if applicable)?  Yes  No F880

### 2. Resident Care

- Are residents on Transmission-Based Precautions restricted to their rooms except for medically necessary purposes? If these residents have to leave their room, are they wearing a facemask or cloth face covering, performing hand hygiene, limiting their movement in the facility, and performing social distancing (efforts are made to keep them at least 6 feet away from others)?
- When residents not on Transmission-Based Precautions are outside of their room, are they wearing a cloth face covering or facemask as part of source control? If a cloth face covering or facemask is not tolerated, does the resident cover his/her mouth and nose with tissues and is reminded or assisted to perform hand hygiene? Is at least 6 feet maintained between residents?
- Is the facility ensuring only COVID-19 negative residents and those not suspected or under observation for COVID-19 are participating in group outings (e.g., if in phase 2 or 3 of CMS' [OSO-20-30-NH](#) - "Nursing Home Reopening Recommendations for State and Local Officials"), group activities, and communal dining following State and local official guidance if more restrictive? Is the facility ensuring that residents are maintaining social distancing (e.g., limited number of people in areas and spaced by at least 6 feet), performing hand hygiene, and wearing cloth face coverings?
- Does the facility have a plan (including appropriate placement and PPE use) to manage residents that are new/readmissions under observation, those exposed to COVID-19, and those suspected of COVID-19? Are these actions based on national (e.g., CDC), state, or local public health authority recommendations?
- Does the facility have a plan to prevent transmission, such as having a dedicated space in the facility for cohorting and managing care for residents with COVID-19? Are these actions based on national (e.g., CDC), state, or local public health authority recommendations?
- For the resident who develops severe symptoms of illness and requires transfer to a hospital for a higher level of care, did the facility alert emergency medical services and the receiving facility of the resident's diagnosis (suspected or confirmed COVID-19) and precautions to be taken by transferring and receiving staff as well as place a facemask or cloth face covering on the resident during transfer (as tolerated)?
- For residents who need to leave the facility for care (e.g., dialysis), did the facility notify the transportation and receiving health care team of the resident's suspected or confirmed COVID-19 status?

2. Did staff provide appropriate resident care?  Yes  No F880

## COVID-19 Focused Survey for Nursing Homes

### 3. IPCP Standards, Policies and Procedures

- Did the facility establish a facility-wide IPCP including standards, policies, and procedures that are current and based on national standards for undiagnosed respiratory illness and COVID-19?
- Do the facility's policies or procedures include when to notify local/state public health officials if there are clusters of respiratory illness or cases of COVID-19 that are identified or suspected?
- Concerns must be corroborated as applicable including the review of pertinent policies/procedures as necessary.

**3. Does the facility have a facility-wide IPCP including standards, policies, and procedures that are current and based on national standards for undiagnosed respiratory illness and COVID-19?**  Yes  No **F880**

### 4. Infection Surveillance

- How many residents and staff in the facility have fever, respiratory signs/symptoms, or other signs/symptoms related to COVID-19?
- How many residents and staff have been diagnosed with COVID-19, and when was the first case confirmed?
- How has the facility established/implemented a surveillance plan, based on a facility assessment, for identifying (i.e., screening), tracking, monitoring and/or reporting of fever, respiratory illness, and/or other signs/symptoms of COVID-19, and immediately isolate anyone who is symptomatic?
- Does the plan include early detection, management of a potentially infectious, symptomatic resident that requires laboratory testing and/or Transmission-Based Precautions/PPE (the plan may include tracking this information in an infectious disease log)?
- Does the facility have a process for communicating diagnosis, treatment, and laboratory test results when transferring a resident to an acute care hospital or other healthcare provider; and obtaining pertinent notes such as discharge summary, lab results, current diagnoses, and infection or multidrug-resistant organism colonization status when residents are transferred back from acute care hospitals?
- Can appropriate staff (e.g., nursing and unit managers) identify/describe the communication protocol with local/state public health officials?
- Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.

**4. Did the facility provide appropriate infection surveillance?**  Yes  No **F880**

### 5. Visitor Entry

- Review for compliance of:
- Screening processes and criteria (i.e., screening questions and assessment of illness);

## COVID-19 Focused Survey for Nursing Homes

- Restricting visitation based on federal or state guidance to ensure visitation does not lead to transmission of COVID-19; and
  - Signage posted at facility entrances for screening and restrictions as well as a communication plan to alert visitors of new procedures/restrictions.
- For those permitted entry, are they instructed to frequently perform hand hygiene; limit their interactions with others in the facility and surfaces touched; restrict their visit to the resident's room or other location(s) designated by the facility; *maintain at least six feet from others in the facility*; and *wear a cloth face covering or facemask during the duration of their visit*? What is the facility's process for communicating this information?

**5. Did the facility perform appropriate screening, restriction, and education of visitors?**  Yes  No **F880**

### 6. Education, Monitoring, and Screening of Staff

- Is there evidence the facility has provided education to staff on COVID-19 (e.g., symptoms, how it is transmitted, screening criteria, work exclusions)?
- How does the facility convey updates on COVID-19 to all staff?
- Is the facility screening all staff at the beginning of their shift for fever and signs/symptoms of illness? Is the facility actively taking their temperature and documenting absence of illness (or signs/symptoms of COVID-19)?
- Are non-essential staff permitted into the facility based on state or federal guidance (e.g., reopening recommendations include phase 1: non-essential staff limited; phase 2: limited numbers of non-essential staff allowed; phase 3: all non-essential staff allowed)?*
- If staff develop symptoms at work (as stated above), does the facility:
- Inform the facility's infection preventionist and include information on individuals, equipment, and locations the person came in contact with; and
  - Follow current guidance about returning to work (e.g., local health department, CDC: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hep-return-work.html>).

**6. Did the facility provide appropriate education, monitoring, and screening of staff?**  Yes  No **F880**

### 7. Reporting to Residents, Representatives, and Families

Identify the mechanism(s) the facility is using to inform residents, their representatives, and families (e.g., newsletter, email, website, recorded voice message):

## COVID-19 Focused Survey for Nursing Homes

- Did the facility inform all residents, their representatives, and families by 5 PM the next calendar day following the occurrence of a single confirmed COVID-19 infection or of three or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours of each other?
- Did the information include mitigating actions taken by the facility to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered (e.g., restrictions to visitations or group activities)?
- Did the information include personally identifiable information?
- Is the facility providing cumulative updates to residents, their representatives, and families at least weekly or by 5 PM the next calendar day following the subsequent occurrence of either: each time a confirmed COVID-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours of each other?
- Interview a resident and a resident representative or family member to determine whether they are receiving timely notifications.

**7. Did the facility inform residents, their representatives, and families of suspected or confirmed COVID-19 cases in the facility along with mitigating actions in a timely manner?**  Yes  No **F885**

**8. Reporting to the Centers for Disease Control and Prevention (CDC) – Performed Offsite by CMS. For consideration by CMS Federal Surveyors only.**

- Review CDC data files provided to CMS to determine if the facility is reporting at least once a week.
- Review data files to determine if all data elements required in the National Healthcare Safety Network (NHSN) COVID-19 Module are completed.

**8. Did the facility report at least once a week to CDC on all of the data elements required in the NHSN COVID-19 Module?**

- Yes  No **F884**

**9. Emergency Preparedness – Staffing in Emergencies**

- Policy development: Does the facility have a policy and procedure for ensuring staffing to meet the needs of the residents when needed during an emergency, such as COVID-19 outbreak?
- Policy implementation: In an emergency, did the facility implement its planned strategy for ensuring staffing to meet the needs of the residents? (N/A if an emergency staff was not needed).

## COVID-19 Focused Survey for Nursing Homes

9. Did the facility develop and implement policies and procedures for staffing strategies during an emergency?

Yes  No E0024  N/A

### 10. Infection Preventionist (IP):

*During interview with facility administration and Infection Preventionist(s), determine the following:*

- Did the facility designate one or more individual(s) as the infection preventionist(s) who are responsible for the facility's IPCP?
- Does the Infection Preventionist(s) work at least part-time at the facility?
- Has the Infection Preventionist(s) completed specialized training in infection prevention and control?
- Does the Infection Preventionist(s) participate in the quality assessment and assurance committee? The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.

*Note: If no to any of the question above, consider citing F882.*

10. Is the facility in compliance with requirements set forth at 483.80(b)?

Yes  No F882

### 11. Staff and Resident Testing

*Review the facility's testing documentation (e.g., logs of county level positivity rate, testing schedules, staff and resident records, other documentation). If possible, observe how the facility conducts testing, including the use of PPE and specimen collection. If such observation is not possible, interview an individual responsible for testing and inquire how testing is conducted (e.g., "what are the steps taken to conduct each test?").*

- Did the facility conduct testing of staff based on the county level positivity rate according to the recommended frequency?
- Based on observation or interview, did the facility conduct testing and specimen collection in a manner that is consistent with current standards of practice for conducting COVID-19 tests?
- Did the facility's documentation demonstrate the facility conducted testing of residents or staff with signs of symptoms of COVID-19 in a manner that is consistent with current standards of practice for conducting COVID-19 tests?

## COVID-19 Focused Survey for Nursing Homes

- Did the facility's documentation demonstrate the facility conducted testing of residents and staff based on the identification of an individual diagnosed with COVID-19 in the facility in a manner that is consistent with current standards of practice for conducting COVID-19 tests?
- Did the facility take actions to prevent the transmission of COVID-19 upon the identification of an individual with symptoms consistent with or who tests positive for COVID-19?
- Did the facility have procedures for addressing residents and staff that refuse testing or are unable to be tested?
- If there was an issue related to testing supplies or processing tests, did the facility contact the state and local health departments for assistance?

Note: If no to any of the question above, consider citing F886.

**11. Is the facility in compliance with requirements set forth at 483.80(h)?**

- Yes  No **F886**

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
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**Center for Clinical Standards and Quality/Survey & Certification Group**

Ref: QSO-20-39-NH

**DATE:** September 17, 2020  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Survey and Certification Group  
**SUBJECT:** Nursing Home Visitation - COVID-19

**Memorandum Summary**

- CMS is committed to continuing to take critical steps to ensure America's healthcare facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- **Visitation Guidance:** CMS is issuing new guidance for visitation in nursing homes during the COVID-19 PHE. The guidance below provides reasonable ways a nursing home can safely facilitate in-person visitation to address the psychosocial needs of residents.
- **Use of Civil Money Penalty (CMP) Funds:** CMS will now approve the use of CMP funds to purchase tents for outdoor visitation and/or clear dividers (e.g., Plexiglas or similar products) to create physical barriers to reduce the risk of transmission during in-person visits.

**Background**

Nursing homes have been severely impacted by COVID-19, with outbreaks causing high rates of infection, morbidity, and mortality.<sup>1</sup> The vulnerable nature of the nursing home population combined with the inherent risks of congregate living in a healthcare setting have required aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within nursing homes.

In March 2020, CMS issued memorandum [QSO-20-14-NH](#) providing guidance to facilities on restricting visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In May 2020, CMS released [Nursing Home Reopening Recommendations](#), which provided additional guidance on visitation for nursing homes as their states and local communities progress through the phases of reopening. In June 2020, CMS also released a [Frequently Asked Questions](#) document on visitation, which expanded on previously issued guidance on topics such as outdoor visits, compassionate care situations, and communal activities.

<sup>1</sup> Information on outbreaks and deaths in nursing homes may be found at <https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg>.



While CMS guidance has focused on protecting nursing home residents from COVID-19, we recognize that physical separation from family and other loved ones has taken a physical and emotional toll on residents. Residents may feel socially isolated, leading to increased risk for depression, anxiety, and other expressions of distress. Residents living with cognitive impairment or other disabilities may find visitor restrictions and other ongoing changes related to COVID-19 confusing or upsetting. CMS understands that nursing home residents derive value from the physical, emotional, and spiritual support they receive through visitation from family and friends. In light of this, CMS is revising the guidance regarding visitation in nursing homes during the COVID-19 PHE. The information contained in this memorandum supersedes and replaces previously issued guidance and recommendations regarding visitation.

### **Guidance**

Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission:

#### **Core Principles of COVID-19 Infection Prevention**

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions or observations about signs or symptoms), and denial of entry of those with signs or symptoms
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose)
- Social distancing at least six feet between persons
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR 483.80(h) (see QSO-20-38-NH)

These core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance for nursing homes, and should be adhered to at all times. Additionally, visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. The risk of transmission can be further reduced through the use of physical barriers (e.g., clear Plexiglas dividers, curtains). Also, nursing homes should enable visits to be conducted with an adequate degree of privacy. Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance.

### **Outdoor Visitation**

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred and can also be conducted in a manner that reduces the risk of transmission. Outdoor visits pose a lower risk of transmission due to increased space and airflow. Therefore, all visits should be held outdoors whenever practicable. Aside from weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), an individual resident's health status (e.g., medical condition(s), COVID-19 status), or a facility's outbreak status, outdoor visitation should be facilitated routinely. Facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, facilities should have a process to limit the number and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining social distancing). We also recommend reasonable limits on the number of individuals visiting with any one resident at the same time.

### **Indoor Visitation**

Facilities should accommodate and support indoor visitation, including visits for reasons beyond compassionate care situations, based on the following guidelines:

- a) There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing;
- b) Visitors should be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;
- c) Facilities should limit the number of visitors per resident at one time and limit the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors; and
- d) Facilities should limit movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Visits for residents who share a room should not be conducted in the resident's room.

NOTE: For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.

Facilities should use the COVID-19 county positivity rate, found on the COVID-19 Nursing Home Data site as additional information to determine how to facilitate indoor visitation:

- Low (<5%) = Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits)
- Medium (5% – 10%) = Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits)
- High (>10%) = Visitation should only occur for compassionate care situations according to the core principles of COVID-19 infection prevention and facility policies

Facilities may also monitor other factors to understand the level of COVID-19 risk, such as rates of COVID-19-Like Illness<sup>2</sup> visits to the emergency department or the positivity rate of a county adjacent to the county where the nursing home is located. We note that county positivity rate does not need to be considered for outdoor visitation.

We understand that some states or facilities have designated categories of visitors, such as “essential caregivers,” based on their visit history or resident designation. CMS does not distinguish between these types of visitors and other visitors. Using a person-centered approach when applying this guidance should cover all types of visitors, including those who have been categorized as “essential caregivers.”

### **Visitor Testing**

While not required, we encourage facilities in medium or high-positivity counties to test visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days) with proof of negative test results and date of test.

### **Compassionate Care Visits**

While end-of-life situations have been used as examples of compassionate care situations, the term “compassionate care situations” does not exclusively refer to end-of-life situations.

Examples of other types of compassionate care situations include, but are not limited to:

- A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support.
- A resident who is grieving after a friend or family member recently passed away.
- A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
- A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

Allowing a visit in these situations would be consistent with the intent of, “compassionate care situations.” Also, in addition to family members, compassionate care visits can be conducted by any individual that can meet the resident’s needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included.

Lastly, at all times, visits should be conducted using social distancing; however, if during a compassionate care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following all appropriate infection prevention guidelines, and for a limited amount of time. Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits.

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<sup>2</sup> For information on COVID-19-Like Illness refer to <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/07102020/covid-like-illness.html>.

### **Required Visitation**

We believe the guidance above represents reasonable ways a nursing home can facilitate in-person visitation. Except for on-going use of virtual visits, facilities may still restrict visitation due to the COVID-19 county positivity rate, the facility's COVID-19 status, a resident's COVID-19 status, visitor symptoms, lack of adherence to proper infection control practices, or other relevant factor related to the COVID-19 PHE. However, facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v). For example, if a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is low or medium, a nursing home **must** facilitate in-person visitation consistent with the regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR 483.10(f)(4), and the facility would be subject to citation and enforcement actions.

Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through windows, or in-person for compassionate care situations, with adherence to transmission-based precautions. However, this restriction should be lifted once transmission-based precautions are no longer required per CDC guidelines, and other visits may be conducted as described above.

### **Access to the Long-Term Care Ombudsman**

As stated in previous CMS guidance QSO-20-28-NH (revised), regulations at 42 CFR 483.10(f)(4)(i)(C) require that a Medicare and Medicaid certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. During this PHE, in-person access may be limited due to infection control concerns and/or transmission of COVID-19; however, in-person access may not be limited without reasonable cause. We note that representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention. If in-person access is not advisable, such as the Ombudsman having signs or symptoms of COVID-19, facilities must, at a minimum, facilitate alternative resident communication with the ombudsman, such as by phone or through use of other technology. Nursing homes are also required under 42 CFR 483.10(h)(3)(ii) to allow the Ombudsman to examine the resident's medical, social, and administrative records as otherwise authorized by State law.

### **Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs**

Section 483.10(f)(4)(i)(E) and (F) requires the facility to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000). P&A programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to "investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported or if there is probable cause to believe the incidents occurred." 42 U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes "the opportunity to meet and communicate privately with such individuals regularly,

both formally and informally, by telephone, mail and in person.” 42 CFR 51.42(c); 45 CFR 1326.27.

Additionally, each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA). For example, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention.

#### **Entry of Health Care Workers and Other Providers of Services**

Health care workers who are not employees of the facility but provide direct care to the facility’s residents, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after being screened. We note that EMS personnel do not need to be screened so they can attend to an emergency without delay. We remind facilities that all staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.

#### **Communal Activities and Dining**

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Residents may eat in the same room with social distancing (e.g., limited number of people at each table and with at least six feet between each person). Facilities should consider additional limitations based on status of COVID-19 infections in the facility. Additionally, group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a face covering. Facilities may be able to offer a variety of activities while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission.

#### **Survey Considerations**

- For concerns related to resident communication with and access to persons and services inside and outside the facility, surveyors should investigate for non-compliance at 42 CFR 483.10(b), F550.
- For concerns related to a facility limiting visitors without a reasonable clinical and safety cause, surveyors should investigate for non-compliance at 42 CFR 483.10(f)(4), F563.
- For concerns related to ombudsman access to the resident and the resident’s medical record, surveyors should investigate for non-compliance at 42 CFR 483.10(f)(4)(i)(C), F562 and 483.10(h)(3)(ii), F583.
- For concerns related to lack of adherence to infection control practices, surveyors should investigate for non-compliance at 42 CFR 483.80(a), F880.

### **Use of CMP Funds to Aid in Visitation**

Technology can help improve social connections for some residents by helping to support and maintain relationships with loved ones. CMS has previously approved the use of CMP funds (See QSO-20-28-NH) to purchase communicative devices, such as tablets or webcams, to increase the ability for nursing homes to help residents stay connected with their loved ones. To ensure a balanced distribution of funds, facilities are limited to purchase one communicative device per 7–10 residents, up to a maximum of \$3,000 per facility.

Additionally, facilities may apply to use CMP funds to help facilitate in-person visits. CMS will now approve the use of CMP funds to purchase tents for outdoor visitation and/or clear dividers (e.g., Plexiglas or similar product) to create a physical barrier to reduce the risk of transmission during in-person visits. Funding for tents and clear dividers is also limited to a maximum of \$3,000 per facility. NOTE: When installing tents, facilities need to ensure appropriate life safety code requirements found at 42 CFR 483.90 are met, unless waived under the PHE declaration.

To apply to receive CMP funds for communicative devices, tents, or clear dividers, please contact your state agency's CMP contact.

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers, and the State/CMS Locations within 30 days of this memorandum.

/s/  
David R. Wright

cc: Survey Operations Group

## Increased Visitation in Long Term Care Facilities

Tennessee Department of Health (TDH) recognizes the difficult challenges long term care facilities have faced in protecting vulnerable residents during the COVID-19 response. This document provides guidance for Tennessee Long Term Care Facilities (skilled nursing facilities, assisted living care facilities, and residential homes for the aged) when establishing steps to gradually “re-open” after closures to visitors due to COVID-19 restrictions. Beginning October 1, 2020, these guidelines will remain in effect until replaced or amended with additional guidance.

Facilities will continue to monitor for COVID-19 cases in residents and staff, through appropriate screening and testing. Facilities should be prepared to discontinue visitation and activities if the facility develops one or more new cases amongst residents or staff.



## Resuming Visitation

### **Visitation Opportunities Always Allowed**

The following visits are always allowed:

- Accommodations or support for residents with disabilities;
- Critical assistance;
- Compassionate care/end-of-life situations; or
- Involvement in a religious exercise.

Visitors must make arrangements with the facility, practice proper social distancing and hand hygiene, and wear a face covering for the duration of their visit.

### **Visitation Opportunities Allowed After 14 Days of no new COVID-19 cases**

Other than in a dedicated wing or unit that accepts COVID-19 cases from the community, facilities that have had no new COVID-19 cases (residents and/or staff) in the previous fourteen (14) days may permit outdoor and limited indoor visitation.

### **Outdoor Visitation**

Outdoor visits on the facility grounds may be conducted as allowed by the following:

- Safe and appropriate outdoor space has been identified on the facility's campus to provide for seating spaced at least six (6) feet apart.
- Program area is only used when weather permits.
- Visits are scheduled in advance;
- Last no more than forty-five (45) minutes.
- Prior to visitation, requirements are acknowledged and agreed upon by the visitors.
- Outdoor visits are limited to not more than two (2) persons (not including the resident) and no children under the age of eighteen (18).
- Visitors are screened before entry into the outdoor visitation area including temperature checks and hand sanitization.
- Residents and visitors wear a face covering and maintain physical distancing.
- Facility establishes sufficient space between individual group seating arrangements, so six (6) feet of physical distancing can be maintained

- between the groups. Capacity should be based on physical space and ability to staff the area.
- Seating accommodations are sanitized by staff between uses. Staff should remain in sight of the visiting group, in order to encourage safety precautions are followed.
- Visitors unable to pass the screening or comply with infection control practices should be prohibited from visiting.
- Visitors should be asked to self-monitor for symptoms of COVID-19 for fourteen (14) days and immediately report any symptoms or positive COVID-19 test to the local health department and the facility.

### **Limited Indoor Visitation**

Indoor visitation should be limited to designated common spaces that allow for appropriate social distancing and cleaning/disinfection between visitors. Visits in designated indoor spaces should include:

- Safe and appropriate indoor space has been identified in the facility to provide for seating spaced at least six (6) feet apart.
- Visits are scheduled in advance.
- Last no more than forty-five (45) minutes.
- Prior to visitation, requirements should be acknowledged and agreed upon by the visitors.
- Indoor visits should be limited to not more than two (2) persons (not including the resident) and no children under the age of eighteen (18).
- Visitors should be screened before entry into the designated indoor area including temperature checks and proper hand sanitization.
- Residents and visitors should always wear a face covering and maintain physical distancing during the visit.
- Facility should establish sufficient space between individual group seating arrangements, so six (6) feet of physical distancing can be maintained between the groups. Capacity is based on physical space and ability to staff the area.
- Seating accommodations should be sanitized by staff between uses. Indoor visitation rooms must follow all applicable life safety guidance.
- Visitors unable to pass the screening or comply with infection control practices should be prohibited from visiting.
- Visitors should be asked to self-monitor for symptoms of COVID-19 for fourteen (14) days and immediately report any symptoms or positive COVID-19 test to the local health department and the facility.

Resident rooms should only be used for visitation as an accommodation for residents who cannot access the designated common area for indoor visitation.

Indoor visitation is allowed in a resident's room when:

- Resident is unable to leave the room **AND**
- Visitor has had negative PCR test collected within previous 72 hours **OR**
- Visitor has negative onsite point-of-care-test at the facility.

**Visitation Opportunities Allowed After 28 Days of no new COVID-19 cases**

In addition to outdoor and limited indoor visitation, once there have been no new COVID-19 cases in the facility's residents or staff for at least twenty-eight (28) days, facilities may also allow for indoor visits by essential caregivers.

**Essential Caregivers**

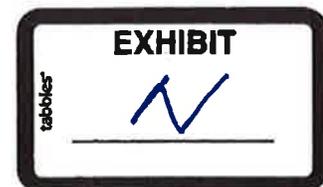
Essential caregivers (EC) are defined by designating a family member or guardian who, prior to visitation restrictions, was regularly engaged with the resident in activities of daily living (bathing, feeding, clothing, etc.) Essential caregiving visitation includes the following:

- Visitation should be scheduled with time restrictions.
- Each resident may have **up to five (5)** individuals designated as an EC although no more than two (2) at a time can visit per resident.
- ECs should be screened before entry into the facility including temperature checks and proper hand sanitization.
- Residents and ECs should wear a face covering and maintain physical distancing from other residents and staff.
- ECs are subject to the regular testing required of the staff (see testing frequency table below as established by CMS Rules). This could be accomplished by:
  - EC has negative PCR test collected within previous 72 hours **OR**
  - EC has negative onsite point-of-care test at the facility.

**Table 2: Routine Testing Intervals Vary by Community COVID-19 Activity Level**

Community COVID-19 Activity	County Positivity Rate in the past week	Minimum Testing Frequency
Low	<5%	Once a month
Medium	5% - 10%	Once a week*
High	>10%	Twice a week*

\* This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.



## **Resuming Activities in Long Term Care Facilities**

Tennessee Department of Health (TDH) recognizes the difficult challenges long term care facilities have faced in protecting vulnerable residents during the COVID-19 response. This document provides guidance for Tennessee Long Term Care Facilities (skilled nursing facilities, assisted living care facilities, and residential homes for the aged) when establishing steps to gradually resume activities, following COVID-19 restrictions. Beginning October 1, 2020, these guidelines will remain in effect until replaced or amended with additional guidance.

Facilities should continue to monitor for COVID-19 cases in residents and staff, through appropriate screening and testing. Facilities should be prepared to discontinue visitation and activities if the facility develops one or more new cases amongst residents or staff.

## **Resuming Facility Activities and Communal Dining**

### **Limitations on Activities and Communal Dining**

Until a facility has gone fourteen (14) days without a new COVID-19 case in residents or staff, there should be limitations in place regarding activities and communal dining. Until fourteen (14) days with no new COVID-19 cases, group activities in common areas should not take place, and meal service should be limited to in-room dining.

### **Activities and Communal Dining Allowed After 14 Days of no new COVID-19 cases**

Facilities may resume resident activities (barber/beautician visits, communal dining, small group social activities, etc.) once there have been no new COVID-19 cases in residents or staff in the facility for fourteen (14) days. Facilities should take into consideration set hours and/or timed entry to ensure proper staffing and cleaning of areas.

- Barbers and beauticians may work in the facility with the following considerations:
  - Barbers and beauticians should wear a face covering for the duration of time in the facility.
  - Barbers and beauticians should remain in the salon area and avoid common areas of the facility.
  - The salon area should utilize staged appointments to maintain distancing of at least six (6) feet apart and not to exceed fifty percent (50%) of capacity.
  - Barbers and beauticians must properly sanitize equipment and salon chairs between each resident, and the barber and beautician must perform proper hand hygiene.
  - Barbers and beauticians must routinely sanitize high-touch areas.
  - Residents must wear a face covering during their visit.
- Volunteer staff may work in the facility with following considerations:
  - Volunteers must follow the same infection control requirements as employed staff, including, but not limited to, universal masking, screening before each shift, and routine testing consistent with CMS guidelines.

**Communal Dining**

- Residents may eat in the dining area maintaining social distancing of at least six (6) feet between tables and no more than two (2) people at a table in order to maintain adequate physical distance between persons.
- A limited number of individuals in a dining area at one time, not to exceed fifty percent (50%) of capacity unless that would be less than ten (10) people.

**Group Activities**

- Small group activities may occur with at least six (6) feet of distancing, proper hand hygiene, and face coverings.
- A limited number of individuals in a common area at one time, not to exceed fifty percent (50%) of capacity, no more than ten (10) people.
- Facilities should restrict activities that encourage multiple residents to handle the same object(s) (e.g., ball toss).

**Therapeutic and Rehabilitation Services**

- A limited number of individuals may be in a therapy and rehabilitation area at one time, not to exceed fifty percent (50%) of capacity, no more than ten (10) people.
- Therapeutic and rehabilitation services may occur in a small group setting (therapy gym) with at least six (6) feet of distancing, proper hand hygiene, and face coverings.
- Equipment is sanitized between uses in accordance with facility policies.

**Accessing the Community: Medically Necessary Trips**

- Telemedicine should be utilized whenever possible.
- Non-medically necessary trips outside the building should be avoided.
- For medically necessary trips:
  - The resident should wear a face covering.
  - The facility must share the resident's COVID-19 status with the transportation service and health care provider with whom the resident has the appointment.
  - Transportation staff, at a minimum, should wear a face covering. Additional PPE may be required.
  - Transportation equipment shall be sanitized between transports.

**Activities Allowed After 28 Days of no new COVID-19 cases**

There are no additional allowances regarding activities at this time.



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
DIVISION OF HEALTH LICENSURE & REGULATION  
OFFICE OF HEALTH CARE FACILITIES  
665 MAINSTREAM DRIVE, SECOND FLOOR  
NASHVILLE, TENNESSEE 37243  
TELEPHONE (615) 741-7221  
FAX (615) 741-7051

PM 83 AMENDED

Board for Licensing Health Care Facilities

Policy Memorandum

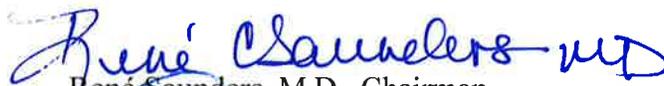
SUBJECT: Extension of Trauma Center Designation Amid COVID-19

DATE: April 1, 2020  
\*June 3, 2020

POLICY: Extend trauma center designation for those trauma centers due re-designation surveys in the month of May for an additional six (6) months.  
  
\*Extends this Board Policy until May 2021 for an additional one (1) year.

EFFECTIVE: April 1, 2020  
\*June 3, 2020

APPROVED: April 1, 2020  
\*June 3, 2020

  
René Saunders, M.D., Chairman  
Board for Licensing Health Care Facilities

  
Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities



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PM 83

Board for Licensing Health Care Facilities

Policy Memorandum

SUBJECT: Extension of Trauma Center Designation Amid COVID-19

DATE: April 1, 2020

POLICY: Extend trauma center designation for those trauma centers due re-designation surveys in the month of May for an additional six (6) months.

EFFECTIVE: April 1, 2020

APPROVED: April 1, 2020

A handwritten signature in blue ink that reads "René Saunders MD".

René Saunders, M.D., Chairman  
Board for Licensing Health Care Facilities

A handwritten signature in blue ink that reads "Ann R. Reed".

Ann R. Reed, RN, BSN, MBA  
Director of Licensure  
Board for Licensing Health Care Facilities



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PM 84

Board for Licensing Health Care Facilities

Policy Memorandum

**SUBJECT:** Hospital 10% Increase in Licensed Beds

**DATE:** December 17, 2020

**POLICY:** The Board hereby adopts HSDA's interpretation that CON holders may request an additional 10% bed increase every three (3) years after the date on which the Health Services and Development Agency (HSDA) has approved any previous 10% bed increase request, pursuant to Tenn. Code Ann. §68-11-1607(g). HSDA shall provide written notification to the Board for Licensing Health Care Facility's administrative staff of its approval of a hospital's licensed bed capacity. Once the written approval is received by HSDA, notification will be made by Board staff to the Board of the HSDA approved bed increase at the Board's regularly scheduled meeting. Facilities will no longer be required to petition the Board for a 10% bed increase, if the action has already been approved by HSDA.

**EFFECTIVE:** December 17, 2020

**APPROVED:** December 17, 2020

René Saunders, M.D., Chairman  
Board for Licensing Health Care Facilities

Ann R. Reed, RN, BSN, MBA  
Director Board for Licensing Health Care Facilities